Arizona Health Care Cost Containment System Administration (AHCCCSA)

AHCCCS

# 2005–2006 External Quality Review Technical Report *for* ALTCS EPD and DDD

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HSAG Health Services Advisory Group

1600 East Northern Avenue, Suite 100 • Phoenix, AZ 85020

Phone 602.264.6382 • Fax 602.241.0757

# CONTENTS

## Introduction

Health Services Advisory Group, Inc., (HSAG) serves as an external quality review organization (EQRO) for the Arizona Health Care Cost Containment System (AHCCCS). This annual technical report complies with 42 Code of Federal Regulations (CFR) 438.364. This report for contract year (CY) 2005–2006 describes how the data from activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed. This report also describes the methodologies used to draw conclusions about the quality and timeliness of and access to the care furnished by the following contractors: Cochise Health Systems, Evercare Select, Mercy Care Plan, Pima Health System, Pinal/Gila Long Term Care, Yavapai County Long Term Care, and the Arizona Department of Economic Security/Division of Developmental Disabilities (DDD). These contractors provided services to Arizona Long Term Care System (ALTCS) members who are elderly or physically disabled (EPD) and those adults and children who are developmentally disabled. This technical report includes the following for each activity conducted in accordance with 42 CFR 438.358:

i. Objectives
ii. Technical methods of data collection and analysis
iii. Description of data obtained
iv. Conclusions drawn from the data
v. The extent to which the State provided the necessary information to create this report while safeguarding the identities of patients

This report also includes an assessment of each contractor's strengths and opportunities for improvement with respect to timely access to quality health care services furnished to Medicaid members and, as applicable, recommendations for improving the quality of the health care services each contractor offers. The requirement to assess the extent to which each contractor has addressed recommendations for quality improvement made as a result of the previous year's review is accomplished through the ongoing system of requiring corrective action plans (CAPs), which is administered and monitored by AHCCCS. Fundamental to this system, for deficiencies in the contractors' performance identified as part of AHCCCS' ongoing monitoring and formal annual operational and financial review processes, the contractors must propose formal CAPs and have them accepted by AHCCCS. Each contractor is also assessed on the extent to which it has addressed recommendations for quality improvement made the previous year (e.g., compliance with State and federal requirements, performance measures, etc.). Comparisons of performance for the EPD contractors related to quality, timeliness, and access are also highlighted.

In this report, the technical methods of data collection and analysis are presented first, which include the technical methods HSAG used in preparing this report and those methods used by AHCCCS and the contractors as they have been mandated by AHCCCS and which do not differ across the contractors. The EQRO assessment of the data obtained for each of the three mandated activities (compliance with standards, performance measures, and performance improvement

projects (PIPs) and the conclusions drawn from those data form the basis for the findings and recommendations, which are presented separately for each contractor as well as comparatively across the EPD contractors. In the final section, the report presents a statewide summary of findings for the EPD contractors, and as applicable, recommendations for continued quality improvement related to the quality and timeliness of and access to care and services.

## AHCCCS' Unique Approach

Each state that contracts with managed care organizations (MCOs) must ensure that it has a qualified EQRO perform an annual external quality review (EQR) for each contracting health plan. The state must ensure that the EQRO has sufficient information to perform the review for each of the EQR-related activities described in 42 CFR 438.358. In addition, the information provided to the EQRO must be obtained through methods consistent with the protocols established under 42 CFR 438.352. In general, the majority of state Medicaid agencies nationwide competitively bid the mandatory activities required by the federal government in seeking competent EQROs to perform these services. AHCCCS, however, is unique not only as a national model program for managed health care, but also for the approach it uses for EQR activities. AHCCCS has developed its own expertise and models for addressing the mandatory activities, including conducting it's own reviews to determine contractor compliance with financial and operational standards, collecting contractor encounter and other data and using the data to directly calculate and measure the contractors' performance for the AHCCCS performance measures and required PIPs, and for validating encounters on which the measurements are based.

AHCCCS reviewed the relevant information, data, and procedures from these activities to determine the extent to which they are accurate, reliable, free from bias, and in accordance with industry standards for data collection and analysis. To meet the mandatory requirements for information that must be produced by an EQRO, AHCCCS contracts with HSAG to provide the external quality review technical report. HSAG is an EQRO that meets the competence and independence requirements set forth in 42 CFR 438.354.

## HSAG Methodology for Data Acquisition and Reporting

On January 19, 2007, AHCCCS and HSAG met to discuss the *EQR Technical Report* contract and AHCCCS' expectations for the technical report of findings from the mandatory activities. AHCCCS provided HSAG with comprehensive documentation of the AHCCCS activities conducted related to the three activities (i.e. determining contractor compliance with select contract and federal requirements, performance measures, and PIPs) and the results obtained for each contractor. HSAG reviewed the documentation provided by AHCCCS and developed a summary tool to crosswalk the data provided related to the contractors' performance with respect to each of the three activities.

Following a preliminary review of the documentation and in order to ensure that HSAG was using complete and accurate information in preparing the technical report, HSAG developed and provided to AHCCCS a list of questions and/or requests for clarification related to the documentation and data provided. AHCCCS responded promptly to HSAG's questions and requests for clarification. As needed throughout the preparation of this report, HSAG communicated with AHCCCS to clarify any remaining questions regarding the data and information and provided monthly written reports to

AHCCCS that described HSAG's progress in completing each of the major activities critical to preparation of the technical report. A first draft of this technical report was provided to AHCCCS for review on April 27, 2007.

# Review of Compliance with Operational and Financial Standards

## *Objectives for Review of Operational and Financial (OFR) Standards*

HSAG designed a tool to organize and represent the information provided by AHCCCS related to the AHCCCS activities conducted and the results of those activities for each of the EPD contractors and for DDD. The summary tool focused on the objectives of this analysis, which were to:

1. Determine each contractor's performance related to standards established by the State to comply with the requirements of the AHCCCS contract and 42 CFR 438.204(g).
2. Provide data from the review of the contractor's performance that would allow conclusions to be drawn as to the quality and timeliness of and access to care furnished by the contractors.
3. Aggregate and analyze the data to provide an overall evaluation of performance.

## *Methodology for Review of Operational and Financial Review Standards*

The AHCCCS mission is stated as: "Reaching across Arizona to provide comprehensive, quality health care for those in need." In support of the mission, AHCCCS conducted a follow-up review for the EPD contractors and an extensive review for DDD. AHCCCS provided each contractor with a description of the applicable review process and, a list of documents and information that were to be made available to AHCCCS for review.

### Elderly and Physically Disabled (EPD) Contractors

CMS requires that an EQR use information from a review conducted within the previous 3-year period to determine the MCOs' compliance with standards established by the state for access to care, structure and operations, and quality measurement and improvement. For the 2004-2005 comprehensive operational and financial review (OFR) of the EPD contractors, AHCCCS conducted a desk audit and on-site review of each contractor's compliance with managed care regulations contained in their contracts with AHCCCS. Based on AHCCCS' findings from the OFR, AHCCCS required each contractor to submit a detailed plan of correction addressing requirements where the contractor was not found to be fully compliant and for which AHCCCS required the contractor to formally submit a CAP. In light of the timing of the AHCCCS procurement process for the EPD contractors that occurred in 2006 and its proximity to the annual compliance review of the current contractors, AHCCCS elected to conduct a focused follow-up review for the 2005-2006 monitoring of contractors' performance related to the standards.

The follow-up desk reviews were conducted to assess the sufficiency of the contractors' CAPs and associated documentation submitted as required in response to significant AHCCCS findings from the prior year (2004–2005) comprehensive OFR. Standards that did not receive an AHCCCS

recommendation that required a CAP in the contract year end (CYE) 2005 operational and financial review were considered fully compliant and were not part of the CYE 2006 follow-up review.

As applicable to each contractor, CAPs were required in one of more of the following categories of AHCCCS standards which comprised the 2004–2005 OFR.

- Administrative Management
- Behavioral Health
- Delivery System
- Encounters
- Financial Management
- Grievance System
- Case Management
- Quality Management
- Utilization Management

The follow-up reviews allowed AHCCCS to:

- Determine the progress and extent to which each contractor had proposed and/or implemented sufficient follow-up corrective actions in response to AHCCCS recommendations from the previous OFR.
- Further increase its knowledge of each contractor's operational and financial procedures.
- Provide technical assistance and identify areas for continued improvement.
- Perform contractor oversight as required by the Centers for Medicare & Medicaid Services (CMS) in accordance with the AHCCCS 1115 waiver.

From its review of the contractor CAPs and associated documentation, AHCCCS determined if: (1) the activities and interventions specified in the corrective action plans could reasonably be anticipated to correct the deficiencies identified during the 2004–2005 OFR and bring the contractor back into compliance with the applicable AHCCCS standards; and/or (2) the associated documentation demonstrated that the contractor had implemented the required action(s) and was now in compliance with one or more of the standards requiring a CAP; and/or (3) additional or revised corrective action plans or documentation were still required from the contractor for one or more standards and the CAP process was still open and continuing. AHCCCS provided each EPD contractor with a letter identifying the standards or substandards in each area that required a CAP as a result of the CY 2005 OFR. The letter also indicated whether additional documentation was required to be submitted to AHCCCS for review. Following its review of the documentation related to the required corrective actions, AHCCCS prepared and issued a letter to each of the contractors summarizing AHCCCS' findings. Follow-up on the implementation of all the required CAPs and related outcomes are reviewed by AHCCCS during ongoing monitoring and oversight activities as well as during future OFRs. These activities determine whether the corrective actions were effective in bringing the Contractor back into compliance with AHCCCS requirements.

In addition to requiring the EPD contractors to submit required CAPs and, as applicable, associated documentation in support of having implemented the corrective actions, AHCCCS also requested that the contractors submit copies of their Network Development and Management Plans and contractor responses/documentation related to new AHCCCS CY 2006 contract requirements.

### Division of Developmental Disabilities (DDD)

For DDD, AHCCCS both (1) provided DDD with a formal response to the DDD CAP submitted in response to the prior year's OFR, and (2) conducted an extensive review of DDD performance in complying with contract requirements. The review team, which was composed of staff members from the Division of Health Care Management and the Office of Legal Assistance, conducted a desk audit of documentation and performed an on-site review, consisting of a review of additional documentation and staff interviews. The review encompassed the following areas:

- Administrative Management
- Behavioral Health
- Delivery System
- Grievance System
- Case Management
- Quality Management
- Medical Management
- Maternal and Child Health

The OFR allowed AHCCCS to:

- Determine the extent to which DDD's performance complied with AHCCCS' contractual requirements and policies, and the Arizona Administrative Code.
- Further increase its knowledge of DDD's operational and financial procedures.
- Provide technical assistance and identify areas for continued improvement and areas of noteworthy performance and accomplishment.
- Review DDD's progress in implementing the recommendations made during the prior OFR.
- Determine DDD's compliance with its own policies and procedures and evaluate their effectiveness.
- Perform contractor oversight as required by CMS in accordance with the AHCCCS 1115 waiver.

AHCCCS prepared a report of its review findings and forwarded it to DDD. In the report, each standard and substandard was individually listed with AHCCCS' evaluation of the degree to which DDD was in compliance with the requirements. The following compliance ratings were used:

- Full Compliance = 90 to 100 percent compliant
- Substantial Compliance = 75 to 89 percent compliant
- Partial Compliance = 50 to 74 percent compliant
- Non-Compliance = 0 to 49 percent compliant
- Not Applicable = N/A
- For Information Only = FIO

The report also included AHCCCS recommendations as follows:

- *The contractor must*… This statement indicates a critical noncompliance area that must be corrected as soon as possible to be in compliance with the AHCCCS contract.
- *The contractor should*… This statement indicates a noncompliance area that must be corrected to be in compliance with the AHCCCS contract but is not critical to the everyday operation of the contractor.
- *The contractor should consider*… This statement is a suggestion by the review team to improve the operations of the contractor but is not directly related to contract compliance.

DDD was required to submit a response to each of the first two types of review findings with a proposed CAP. AHCCCS approves the initial or, as requested by AHCCCS, revised CAPS submitted by the contractors. All contractors, including DDD, have the right to challenge AHCCCS' findings.

## Validation of Performance Measures

### *Objectives for Review of Performance Measures*

In its objectives for the review of validation of performance measures, AHCCCS:

1. Provided each contractor with the necessary information on State-required performance measures.
2. Used the contractor encounter/other data submitted to AHCCCS to calculate the performance measure rates.
3. Conducted validation of encounter data according to industry standards.

### *Methodology for Review of Performance Measures*

AHCCCS calculated the ALTCS performance measures by using a combination of administrative data collected from the Prepaid Medicaid Management Information System (PMMIS) and data collected from medical and/or case management records. Sample members and services meeting numerator criteria were selected from the Recipient and Encounter subsystem of the PMMIS. Additional data were collected by the contractors, which provided supporting documentation (e.g., a copy of the pertinent section of the medical record).

The exception to this hybrid data collection methodology was the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Participation Rate, which was collected solely from administrative data, according to a methodology developed by CMS for the EPSDT "Form 416" report that is required annually of all states. The EPSDT participation rate for CYE 2006 (based on the measurement period CYE 2005) had been calculated by AHCCCS, but had not yet been reported to contractors; therefore, the aggregate rate is not included in this report.

Performance measure results calculated and reported by AHCCCS for each contractor were compared with standards defined by contract. When a contractor had not met the minimum AHCCCS performance standard for the most recent measurement period, AHCCCS required the contractor to develop a CAP. The CAP was to include an evaluation of the effectiveness of current

interventions and, when necessary, plans to revise or replace those interventions to improve the performance measure rates.

Because some measures are reported on a biennial basis, not all performance measures in the contract were publicly reported by AHCCCS in 2006. The performance measures reported for the EPD contractors (i.e., Cochise Health Systems, Evercare Select, Mercy Care Plan, Pima Health System, Pinal/Gila Long Term Care, and Yavapai County Long Term Care) include:

- Initiation of Home and Community-Based Setting (HCBS) Services
- Diabetes Management—HbA1c Testing
- Diabetes Management—Lipid Screening
- Diabetes Management—Retinal Exams
- EPSDT Participation

The performance measures reported for DDD include:

- Well-Child Visits in the First 15 Months[2-1]
- Well-Child Visits—3 to 6 Years[2-2]
- Adolescent Well-Care Visits[2-2]
- Annual Dental Visits
- Child Immunization—4 DTaP
- Child Immunization—3 IPV
- Child Immunization—1 MMR
- Child Immunization—3 HiB
- Child Immunization—3 HBV
- Child Immunization—1 VZV
- Child Immunization—DTP, IPV, & MMR (4:3:1 Series)
- Child Immunization—DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series)
- EPSDT Participation[2-3]

Vaccination data for a newly reported set of measures were collected from the Arizona State Immunization Information System, the State's immunization registry, and from medical records collected by contractors. AHCCCS utilizes an EQRO to merge and analyze these data.

After results are publicly reported, AHCCCS notifies contractors whether they must submit or continue CAPs. The performance measures included in this report were reported by AHCCCS for

[2-1] Only one member met the continuous enrollment criteria for Well-Child Visits in the First 15 Months of Life, so a rate could not be calculated for this measure.

[2-2] Baseline rates for Well-Child Visits 3 to 6 Years, and Adolescent Well-Care Visits are being used to establish DDD Performance Standards for the CYE 2007 contract renewal.

[2-3] The EPSDT Participation rate is the number of children younger than 21 years of age receiving at least one medical screen during the contract year, compared to the number of children expected to receive at least one medical screen. The number of children expected to receive at least one medical screen is based on the AHCCCS EPSDT periodicity schedule and the average period of eligibility. This is the first measurement period for EPSDT Participation.

CYE 2006, based on the measurement period CYE 2005. In early 2007, AHCCCS requested CAPs from contractors that did not meet the minimum standard for one or more of the measures.

To adjust the previous statewide averages for comparability with the present year, AHCCCS removed the data for Maricopa LTC from the previous remeasurement statewide rates reported last year, as Maricopa LTC was not a current contractor for AHCCCS. Through this recalculation, the current and previous statewide rates are comparable for this report, but the current statewide rates will not be identical to the rates from the same time period that were reported last year.

AHCCCS estimated the overall accuracy of the contractors' encounter data using two measures. These measures were the ALTCS "A" and "B" encounter data validation rates. The ALTCS "A" rate includes home health, therapies, and personal care. The ALTCS "B" rate includes nursing facilities' encounter omissions, which is defined as the percentage of paid claims not reported to AHCCCS as encounters. The overall weighted omission rates for all contractors were 4.6 percent and 0.0 percent for ALTCS "A" and "B," respectively.

## Assessment of Performance Improvement Projects (PIPs)

### *Objectives for Review of PIPs*

In its objectives for the assessment of PIPs, AHCCCS:

1. Ensured that each contractor (EPD and DDD) had an ongoing performance improvement program of projects that focused on clinical and non-clinical areas for the services it furnished to members.
2. Ensured that each contractor measured performance using objective and quantifiable quality indicators.
3. Ensured that each contractor implemented interventions to achieve improvement in quality.
4. Evaluated the effectiveness of each contractor's interventions.
5. Ensured that each contractor planned and initiated activities to increase or sustain improvement.
6. Ensured that each contractor reported the status and results of each project to the State in a reasonable period to allow timely information regarding the success of PIPs.
7. Calculated and, for the Diabetes PIP, validated the PIP results from the health plan data/information submitted to AHCCCS.
8. Annually reviewed the impact and effectiveness of each contractor's performance improvement program.
9. Required that each contractor have an ongoing process to evaluate the impact and effectiveness of its performance improvement program.

## Methodology for Review of PIPs

AHCCCS required that each contractor have an ongoing program of PIPs that focused on clinical and non-clinical areas. These projects involved measuring performance by using objective and quantifiable quality indicators, implementing system interventions to achieve performance improvements, evaluating the effectiveness of the interventions, and planning and initiating activities to increase or sustain improvements.

The PIPs reviewed for this *EQR Technical Report* were diabetes management and comorbid disease management for the EPD contractors and diabetes management and children's oral health for DDD.[2-4] Throughout the data gathering and analytic processes, AHCCCS maintained confidentiality in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements. The files were maintained on a secure, password-protected computer. Only AHCCCS employees who analyzed the data had access to the database, and all employees were required to sign confidentiality agreements. Only the minimum amount of necessary information to complete the project was collected. Upon completion of each study, all information was removed from the AHCCCS computer and placed on a compact disc to be stored in a secure location.

After the data were collected and processed, PIPs were reviewed and assessed by AHCCCS through the use of the criteria found in *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities* (Department of Health and Human Services, Centers for Medicare & Medicaid Services, Final Protocol, Version 1.0, May 1, 2002). This process involved 10 distinct steps as delineated in the CMS protocol:

1. Review the selected study topic(s)
2. Review the study question(s)
3. Review selected study indicator(s)
4. Review the identified study population(s)
5. Review sampling methods (if sampling was used)
6. Review the contractor's data collection procedures
7. Assess the contractor's improvement strategies
8. Review data analysis and interpretation of study results
9. Assess the likelihood that reported improvement is real improvement
10. Assess whether the contractor has sustained documented improvement

The methodology for evaluating each of the 10 steps is covered in detail in the CMS protocol, including acceptable and not acceptable examples of each step. When completed, the PIP assessment was forwarded to each contractor who then had the opportunity to comment on the results and AHCCCS-required CAPs. AHCCCS provided the overall AHCCCS evaluation reports and contractor-specific results to HSAG for review and to include the relevant information in this *EQR Technical Report.*

[2-4] Evercare did not demonstrate significant and sustained improvement during the previous remeasurement period; therefore, Evercare rates reported are from a year more recent than for the other contractors (i.e., Oct. 1, 2003–Sept. 30, 2004 and Oct. 1, 2004–Sept. 30, 2005).

# Overall Review Findings for All EPD Contractors

## *Compliance with AHCCCS' Required Corrective Actions Related to the 2004–2005 Operational and Financial Review of Standards*

As described in Section 2, AHCCCS elected to conduct a focused follow-up review for the 2005-2006 review of EPD contractor performance related to compliance with AHCCCS standards. The follow-up desk reviews conducted by AHCCCS were to assess the sufficiency of the contractors' CAPs and associated documentation submitted as required in response to significant AHCCCS findings from the prior year's (2004–2005) comprehensive OFR. AHCCCS reviewed and assessed each contractor's proposed corrective action plans and associated documentation. From its review of the contractor CAPs and documentation, AHCCCS determined if: (1) the activities and interventions specified in the corrective action plans could reasonably be anticipated to correct the deficiencies identified during the 2004–2005 OFR and bring the contractor back into compliance with the applicable AHCCCS standards; and/or (2) the documentation demonstrated that the contractor had implemented the required action(s) and was now in compliance with one or more of the standards requiring a CAP; and/or (3) additional or revised corrective action plans or documentation were still required from the contractor for one or more standards and the CAP process was still open and continuing. Follow-up on the implementation of the CAPs and related outcomes are reviewed by AHCCCS during ongoing monitoring and oversight activities as well as during future OFRs. These activities determine whether the corrective actions were effective in bringing the contractor back into compliance with AHCCCS requirements.

The 2005–2006 follow-up reviews assessed the applicable required CAPs and associated documentation for each contractor in the following areas that comprised the 2004–2005 comprehensive OFR.

- Administrative Management
- Behavioral Health
- Delivery System
- Encounters
- Financial Management
- Grievance System
- Case Management
- Quality Management
- Utilization Management

In addition to requiring the EPD contractors to submit requested documentation in support of having implemented select corrective actions, AHCCCS also requested that the contractors submit copies of their Network Development and Management Plans and their responses and documentation related to new AHCCCS CY 2006 contract requirements.

Table 3-1 presents each of the nine categories of technical standards assessed for the 2004–2005 comprehensive OFR, total number of technical standards in each category, the number and percentage of CAPs required based on AHCCCS' findings from the OFR, and the number of continuing CAPs following AHCCCS' review of the CAPs and associated documentation submitted by the contractors. The table presents data for the six EPD contractors, i.e., Cochise, Evercare, Mercy Care, Pima, Pinal/Gila, and Yavapai. These are the same contractors for which data is presented for all of the statewide results in this report.[3-1]

**Table 3-1—Overview of Total CAPs Required *for* All EPD Contractors**

| Categories of Technical Standards | Total Number of Standards Across EPD Contractors CY 2004-2005 | Number (%) of CY 2004–2005 CAPs | Number of CY 2005–2006 Continuing CAPs |
|---|---|---|---|
| Administrative Management | **150** | 20 (13%) | 0 |
| Behavioral Health | **48** | 10 (21%) | 0 |
| Delivery System | **95** | 3 (3%) | 0 |
| Encounters | **90** | 7 (8%) | 0 |
| Financial Management | **78** | 8 (10%) | 0 |
| Grievance System | **96** | 21 (22%) | 0 |
| Case Management | **30** | 3 (10%) | 0 |
| Quality Management | **66** | 23 (35%) | 1 |
| Utilization Management | **66** | 21 (32%) | 1 |
| **Total** | **719** | **116 (16%)** | **2** |

Table 3-1 shows that only two continuing CAPs remained open following AHCCCS' 2005–2006 follow-up review of the EPD contactors' CAPs and related documentation. The continuing CAPs were in two different categories (i.e., Quality Management and Utilization Management) and were for two different contractors with one continuing CAP remaining for each contractor.

## Performance Measure Review

Table 3-2 presents the mean rates across the six EPD contractors. The table shows the following data: the previous performance,[3-2] the current performance, the relative percentage change, the statistical significance of the change, the CYE 2005 minimum AHCCCS performance standard, the AHCCCS goal, and the AHCCCS long-range benchmark. The increasing minimum AHCCCS performance standards reflect AHCCCS' commendable efforts to continuously drive improvement in timely access to quality care.

[3-1] The results of the reviews for all three activities for the Department of Economic Security/Division of Developmental Disabilities (DDD) measures are shown separately and last in this chapter.

[3-2] The rates for the October 1, 2003 to September 30, 2004 measurement period have been recalculated by AHCCCS to reflect the removal of Maricopa LTC data, due to the change in the contractor status as an EPD contractor. The presented rates, therefore, differ from the rates presented in last year's report.

| Table 3-2—Performance Measurement Review *for* All EPD Contractors | | | | | | | |
|---|---|---|---|---|---|---|---|
| Performance Measure | Actual Performance for Oct. 1, 2003 to Sept. 30, 2004 | Actual Performance for Oct. 1, 2004 to Sept. 30, 2005 | Relative Percent Change | Significance Level* | CYE 2005 Minimum AHCCCS Performance Standard | AHCCCS Goal | AHCCCS Long-Range Benchmark |
| Initiation of HCBS** | 90.1% | 89.1% | -1.2% | p=.597 | 84% | 85% | 98% |
| Diabetes Management—HbA1c Testing | 75.2% | 74.8% | -0.5% | p=.845 | 75% | 77% | 85% |
| Diabetes Management—Lipid Screening | 70.8% | 73.6% | 3.9% | p=.177 | 76% | 78% | 81% |
| Diabetes Management—Retinal Exams | 51.1% | 66.6% | 30.4% | p<.001 | 45% | 47% | 64% |
| EPSDT Participation | N/A | N/A | N/A | N/A | 50% | 53% | 80% |

Notes:

* Significance Levels (p-value) noted in the table were performed by AHCCCS and demonstrate the statistical significance between the performance for the previous remeasurement period and actual performance for the current period. Statistical significance is traditionally reached when the p-value ≤ .05.

**HCBS is Home and Community-Based Services.

AHCCCS removed Maricopa LTC data from the previous statewide remeasurement rates as Maricopa was not a current EPD contractor, thereby changing the currently reported previous remeasurement rates from those reported last year.

N/A is shown because AHCCCS did not include an overall score (for all contractors) for the EPSDT participation rates. The EPSDT Participation rate, which is newly reported for CYE 2006, was calculated by AHCCCS but had not yet been reported to contractors.

Table 3-2 shows mixed performance, statewide, with the rates for two of the measures improving and two declining. The rate for the retinal exam measure was the only rate that changed by a statistically significant amount (i.e., $p \leq .05$). The statewide rate for the initiation of HCBS declined from 90.1 percent to 89.1 percent. The amount of the decrease in the rate was not statistically significant. This finding suggests that the rate has been somewhat stable over the two-year period presented. The previous and current rates exceeded both the CYE 2005 minimum AHCCCS performance standard and the AHCCCS goal.

The statewide rate for diabetes management—HbA1c testing declined from 75.2 percent to 74.8 percent, but the amount was not statistically significant (i.e., $p \leq .05$). The relative percentage decline was -0.5 percent. As suggested above, the finding of statistical non-significance suggests that the rates for the measures have also been fairly stable over the two-year period shown. The rate for diabetes management—HbA1c testing had exceeded the CYE 2005 minimum AHCCCS performance standard in the previous measurement year, but did not do so in the current year. The rate for this measure, by not currently reaching the AHCCCS minimum standard, presents an opportunity for improvement.

For diabetes management—lipid screening, the rate improved statewide from 70.8 percent to 73.6 percent, a relative improvement of 3.9 percent, but was not enough to reach statistical significance (i.e., $p \leq .05$). The statewide rate, which is below the AHCCCS quality performance targets, presents an opportunity for improvement for this aspect of adult diabetes management.

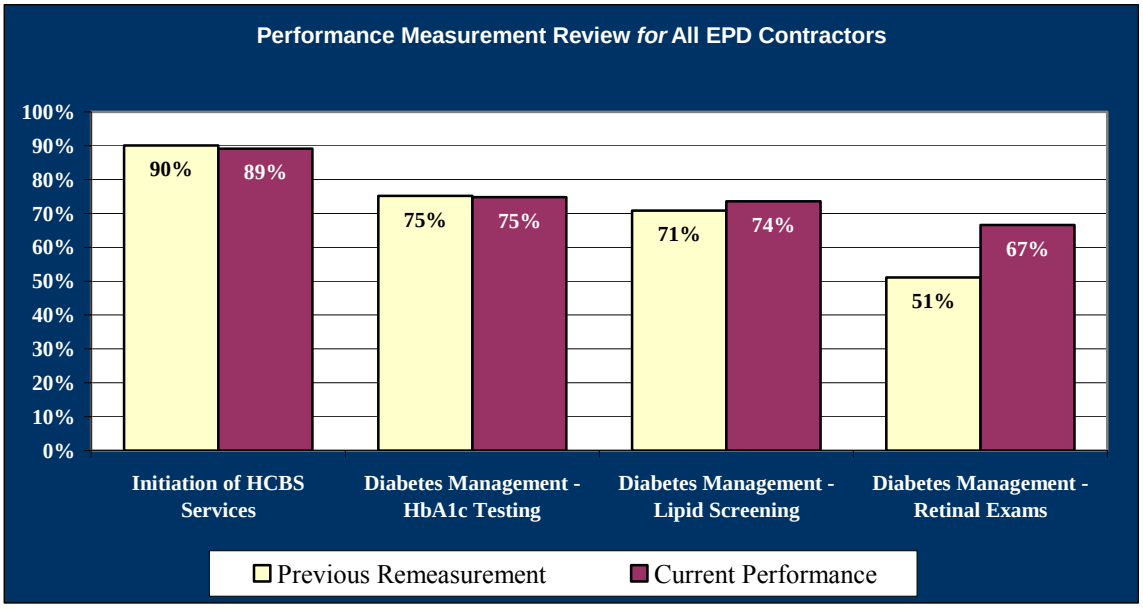
For diabetes management—retinal exams, the high current statewide rate and the large average change in rates between the two most recent measurement periods are commendable for the contractors as a

group. The statewide average rate increased from 51.1 percent to 66.6 percent, a relative increase of 30.4 percent ($p < .001$). The current statewide rate also exceeds the AHCCCS long-range benchmark.

The EPSDT participation measure was new in CYE 2006. For this reason, comparative data do not exist. Nonetheless, the criterion for acceptable standards of care exists in the form of the AHCCCS minimum performance standard, goal, and long-range benchmark. The EPSDT participation rate for CYE 2006 (based on the measurement period CYE 2005) had been calculated by AHCCCS, but had not yet been reported to contractors; therefore, the aggregate rate is not included in this report.

The above results are also presented in Figure 3-1. The figure shows the statistically flat performance for the initiation of HCBS measure and the two diabetes management measures: HbA1c testing and lipid screening. The strong performance results for the previous measurement could understandably have made substantive increases in rates more difficult to achieve. The figure also shows, however, the substantive increase in the retinal exams measure.

**Figure 3-1—Change in Performance Measure Rates *for* All Contractors**




## Performance Measures—CAPs

AHCCCS increased the minimum performance standards between the two most recent review periods. These increases can be interpreted, but the number of CAPs cannot be compared. Table 3-3 shows both the magnitude and the effect of these changes on the number of required CAPs for the contractors' performance measures. The table presents the following: data for each of the performance measures: the previous number of CAPs, the minimum AHCCCS performance standard in effect at the time of the previous required CAPs, the current number of CAPs, and the minimum AHCCCS performance standard for the current number of CAPs.

**Table 3-3–Performance Measures—Corrective Action Plan Required *for* All EPD Contractors**

| Performance Measure | Previous CAPs for Oct. 1, 2003 to Sept. 30, 2004 | Previous Minimum AHCCCS Performance Standard | Current CAPs for Oct. 1, 2004 to Sept. 30, 2005[1] | Current Minimum AHCCCS Performance Standard |
|---|---|---|---|---|
| Initiation of HCBS* | 0 | 74.0% | 0 | 84% |
| Diabetes Management—HbA1c Testing | 0 | 51.0% | 3 | 75% |
| Diabetes Management—Lipid Screening | 0 | 47.0% | 3 | 76% |
| Diabetes Management—Retinal Exam | 0 | 31.0% | 0 | 45% |
| EPSDT Participation | N/A | N/A | 2 | 50% |
| **Total Performance Measure CAPs** | **0** | | **8** | |

*HCBS is Home and Community-Based Services.

N/A is due to the measure being new for CYE 2006

[1]CAPs had not formally been required when the documentation was provided by AHCCCS.

Table 3-3 shows the previous number of CAPs (i.e., from October 1, 2003 to September 30, 2004) compared with the current number of CAPs (i.e., from October 1, 2004 to September 30, 2005). As noted above, the number of CAPs cannot be compared, given the increases in the AHCCCS minimum performance standards. For this reasons, the report focuses on only the eight required CAPs from the most recent measurement cycle.

The eight required CAPs were fairly evenly distributed across two measures of diabetes management (i.e., HbA1c testing and lipid screening) and EPSDT participation. Both diabetes measures were statistically flat, meaning that little recognizable change has taken place at the statewide level. The EPSDT participation measure is in its first year of reporting, and two of six contractors have a required CAP.

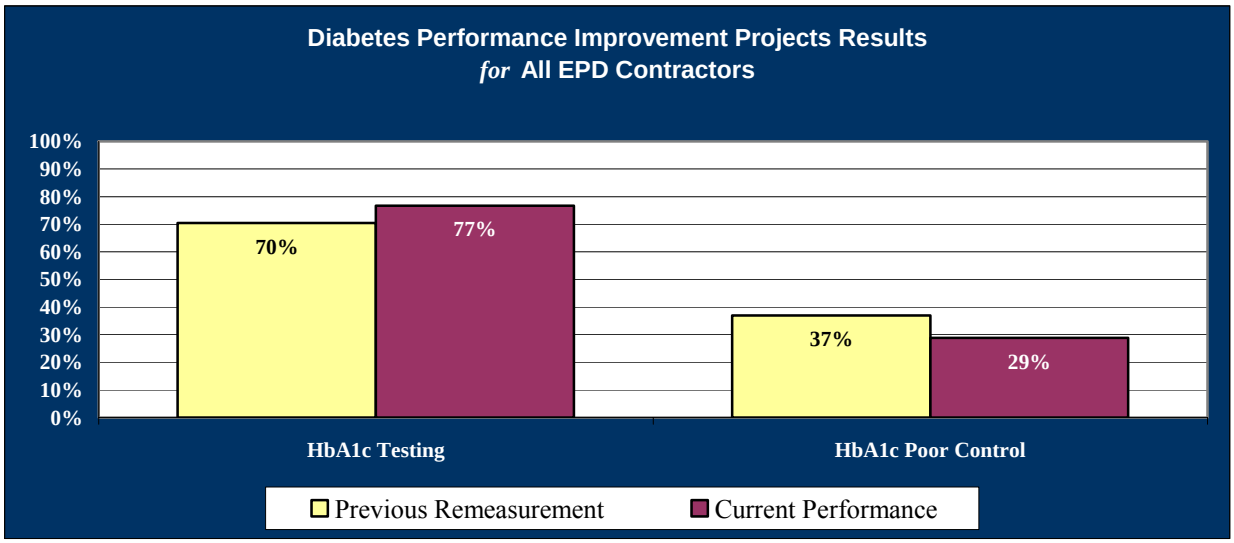
These statewide results can obscure the contractor-specific findings. The eight required CAPs were distributed among five of the six contractors. Three of the contractors had two required CAPs each, two contractors had one required CAP each, and the sixth contractor did not have any required CAPs for the performance measure review. The associated opportunities and recommendations for improvement, therefore, are found in the contractor-specific sections of the report.

The results suggest important opportunities for improvement for five contractors for two of the three measures of diabetes management—HbA1c testing and lipid screening—and for EPSDT participation. The diabetes management measures are not new to the contractors and have been the targets of research and practice for quality improvement efforts nationwide. Lastly, the minimum AHCCCS performance standards appear attainable for all of the measures, as demonstrated by the fact that at least one of the six contractors performed at a level that exceeded the minimum AHCCCS performance standards for all of the measures.

## Review of PIPs

Figure 3-2 presents the change in PIP performance for the two most recent measurement periods averaged across the EPD contractors. The figure shows improvement in both measures of diabetes management and control. The current statewide rate for HbA1c testing is 77 percent, which is still somewhat below the 50th percentile from the 2005 national Health Plan Employer Data and Information Set (HEDIS®)[3-3] Medicaid results of 78.4 percent.[3-4] The statewide HbA1c poor control rate of 29 percent exceeds the 90th percentile from the 2005 national HEDIS Medicaid results, which is 31.1 percent.[3-5] Statewide, the rate for HbA1c poor control is a recognized strength for the contractors' improvement programs. The diabetes management PIP has been closed by AHCCCS as of the current reporting cycle. A description of the closeout of the PIP for each contractor is included in the contractor-specific findings.

**Figure 3-2—Change in PIP Study Indicator Rates *for* All EPD Contractors**




The management of the comorbid disease PIP was started by the contractors during the current review cycle. Table 3-4 presents the statewide baseline results for this PIP, including the mean number of impatient days, mean number of emergency room/urgent care (ER/UC) visits, and mean number of outpatient encounters. The next review cycle will include an assessment of progress on this PIP.

[3-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[3-4] The rates for Evercare were from CYE 2005, due to their not having previously attained and sustained sufficient improvement in the prior measurement cycles.
[3-5] The reason that the lower rate of 29 percent exceeds the 90th percentile rate of 31.1 percent is the reversed structure of the measure whereby lower rates are indicative of better performance.

| Table 3-4—Performance Improvement Projects—Comorbid Disease *for* All EPD Contractors | |
|---|---|
| **PIP Measure** | **Statewide Baseline Measure—October 1, 2002–September 30, 2003** |
| Mean Number of Inpatient Days | 15.92 |
| Mean Number of ER/UC Visits | 0.59 |
| Mean Number of Outpatient Encounters | 59.58 |
| Note: The denominator for all three measures is the number of eligible members in the sample frame who reside in their home and have at least two of the specified diseases. | |

## *Overall Strengths, Opportunities for Improvement, and Recommendations for the EPD Contractors*

The next three sections discuss: (1) findings from AHCCCS' assessment of the sufficiency of the contractors' corrective action plans which were required by AHCCCS as a result of the findings from the prior year's full OFR, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths for the area of review that were found in the documentation provided to HSAG and, as applicable, opportunities for improvement, and recommendations.

### Compliance with Standards (Operational and Financial Review)

### Strengths

The CYE 2005 OFR of the contractors' compliance with the technical standards identified several opportunities for improvement that were common to all of the contractors. These common areas included such requirements as:

- Ensuring contractors have prior authorization policies and procedures that authorize services in sufficient amount, duration, and scope to achieve their intended purpose.
- Ensuring that members are properly educated on program policies, including their ability to request a copy of their medical record at no cost to the member.
- Ensuring that contractor staff members are properly trained to identify behavioral health needs and coordinate behavioral health services in a timely manner.

Following AHCCCS' review and assessment of each contractors' CAPs and associated documentation, AHCCCS determined that for all but 2 of the 116 CAPs, the activities and interventions specified in the CAPs/associated documentation: (1) could be reasonably anticipated to correct the identified deficiencies and bring the contractors back into compliance with the AHCCCS standards and/or (2) demonstrated that the contractors had already completed the activities/interventions and were now in compliance with the one or more of the standards for which a CAP was required.

### Opportunities for Improvement and Recommendations

With only two continuing CAPs statewide and the required CAP different for each of two of the contractors, HSAG offers no overall opportunities for improvement or recommendations for the compliance with standards review. The opportunities for improvement and recommendations for the two continuing CAPs are discussed in the applicable contractor-specific sections of this chapter.

## Performance Measure Review

### Strengths

The rates for the initiation of HCBS and for the retinal exams for diabetics are both recognized strengths statewide. Neither measure required a CAP from any of the six contractors, even with the noted increase in the minimum AHCCCS performance standards between the previous and the current review cycles.

### Opportunities for Improvement and Recommendations

Two measures of diabetes management (i.e., HbA1c testing and lipid screening) saw required CAPs for three of the six contractors. Both measures are opportunities for improvement for the three impacted contractors. A statewide recommendation for improving those measures that require blood-testing is for the contractors to consider implementing or enhancing the availability of care/service delivery models in which drawing the required blood samples is done during routine medical visits. If current access requires members to make separate trips or make an appointment with a testing center, this could be a barrier to improving the rates for diabetic testing and screening. When fewer member trips and appointments can accomplish the same set of goals, it seems reasonable to anticipate that the rates might improve. In addition, when talking with a physician who states tests are needed and can be done right away, some members, who would otherwise not follow-up with a second appointment, might agree to have the blood drawn at that time. Combined with enhanced provider office and member reminder systems, the additional member convenience might be very effective in improving the rates.

The EPSDT participation rates are also opportunities for improvement for two of the EPD contractors. Improving EPSDT participation rates often involves a combination of strategies (e.g., enhancing access to evening and weekend appointment times to accommodate working parents/guardians; strengthening member/parent/guardian educational materials related to content and to the frequency and method of delivery; enhancing member scheduling and reminder services; and initiating or enhancing systems for provider performance recognition/incentives and/or sanctions/withholds.

## Review of PIPs

### Strengths

The diabetes PIP has been closed and is seen as a somewhat qualified statewide strength for the contractors. Although the PIP was successful, as evidenced by the contractors improving the study indicator rates by a statistically significant amount and sustaining that improvement, the final statewide rate for HbA1c testing had not reached the 50th percentile from the 2005 national HEDIS

Medicaid results of 78.4 percent. In contrast, the statewide result for the HbA1c poor control measure was among the best in the country. The statewide average (i.e., 29 percent) was better than the 90th percentile from the 2005 national HEDIS Medicaid results (i.e., 31.1 percent).[3-6] This measure, therefore, is viewed as an unqualified success at the statewide level.

The comorbid disease PIP is new this year. For that reason, there are no statewide strengths to report in the current review cycle. It is anticipated that the next review cycle will include a comparative results section for the comorbid disease PIP.

## Opportunities for Improvement and Recommendations

As the diabetes management PIP has been closed and statewide performance improved and, for one of the measures, was strong from a national perspective, and as only baseline data was available for the new comorbid disease PIP, there are no opportunities for improvement or recommendations offered related to the contractors' statewide performance for PIPs for this review.

[3-6] Being structured so that 0 percent is perfect, lower rates are indicative of better performance.

# Cochise Health Systems (Cochise)

## *Compliance with AHCCCS' Required Corrective Actions Related to the Standards (Operational and Financial Review)*

For Cochise, Table 3-5 presents each of the nine categories of technical standards assessed for the CY 2004–2005 comprehensive OFR, total number of technical standards in each category, number of CAPs required, and number of continuing CY 2005–2006 CAPs for each category.

**Table 3-5—Overview of Total CAPs Required *for* Cochise**

| Categories of Technical Standards | Total Number of Standards CY 2004-2005 | Number of CY 2004–2005 CAPs | Number of Continuing CY 2005–2006 CAPs |
|---|---|---|---|
| Administrative Management | **25** | 4 | 0 |
| Behavioral Health | **8** | 1 | 0 |
| Delivery System | **16** | 0 | 0 |
| Encounters | **15** | 2 | 0 |
| Financial Management | **12** | 2 | 0 |
| Grievance System | **16** | 0 | 0 |
| Case Management | **5** | 1 | 0 |
| Quality Management | **11** | 3 | 0 |
| Utilization Management | **11** | 6 | 0 |
| **Total** | **119** | **19** | **0** |

The CY 2004–2005 review identified one or more areas requiring improvement within most of the categories of technical standards, resulting in 19 required CAPs. In assessing the sufficiency of the CAPs/associated documentation, AHCCCS determined that for all of the 19 required CAPs, the activities and interventions specified in the CAPs/associated documentation: (1) could be reasonably anticipated to correct the identified deficiencies and bring Cochise back into compliance with the AHCCCS standards and/or (2) demonstrated that Cochise had already completed the activities/interventions and was now in compliance with the one or more of the standards for which a CAP was required.

Cochise's performance improvement activities were directed, in part, toward: updating policies and procedures; increasing provider monitoring; enhancing member education; strengthening quality management reporting; and enhancing staff training.

## Performance Measure Review

Table 3-6 presents the performance measure rates for Cochise. The table shows the following information: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, the CYE 2005 minimum AHCCCS performance standard, the AHCCCS goal, and the AHCCCS long-range benchmark.

**Table 3-6—Performance Measurement Review *for* Cochise**

| Performance Measure | Actual Performance for Oct. 1, 2003 to Sept. 30, 2004 | Actual Performance for Oct. 1, 2004 to Sept. 30, 2005 | Relative Percent Change | Significance Level* | CYE 2005 Minimum AHCCCS Performance Standard | AHCCCS Goal | AHCCCS Long-Range Benchmark |
|---|---|---|---|---|---|---|---|
| Initiation of HCBS** | 98.2% | 95.6% | -2.7% | p=.584 | 84% | 85% | 98% |
| Diabetes Management—HbA1c Testing | 88.4% | 79.4% | -10.2% | p=.101 | 75% | 77% | 85% |
| Diabetes Management—Lipid Screening | 69.8% | 78.4% | 12.3% | p=.185 | 76% | 78% | 81% |
| Diabetes Management—Retinal Exams | 48.8% | 68.0% | 39.3% | p=.008 | 45% | 47% | 64% |
| EPSDT Participation | N/A | 95.0% | N/A | N/A | 50% | 53% | 80% |

Notes:

*Significance Levels (p-value) noted in the table were performed by AHCCCS and demonstrate the statistical significance between the performance for the previous remeasurement period and actual performance for the current period. Statistical significance is traditionally reached when the p-value ≤ .05.

**HCBS is Home and Community-Based Services.

N/A is shown because EPSDT participation rates were newly reported for CYE 2006.

Table 3-6 shows mixed performance for Cochise, with the rates for two of the measures improving and two declining, although only the rate for the retinal exams measure changed by a statistically significant amount (i.e., p≤ .05). The initiation of HCBS rate remained well above the minimum AHCCCS performance standard and AHCCCS goal; therefore, performance for this measure is a strength for the contractor. Nonetheless, while not statistically significant, variables impacting the recent decline in the rate may be something that Cochise may want to explore.

The rate for the HbA1c testing measure for diabetes management declined by a relative 10.2 percent between measurement periods, but the amount was not statistically significant. The final rate of 79.4 percent was above the AHCCCS goal of 77 percent. This measure is considered a strength for the contractor, even though an opportunity for improvement may exist related to reversing the current decline in performance.

The diabetes management—lipid screening rate improved by a relative 12.3 percent between the two most recent measurement periods. This amount of improvement was not statistically significant, but was of substantive significance in so far as the increase was sufficient to exceed the AHCCCS goal. Given that the final rate of 78.4 percent is above the AHCCCS goal, the measure is considered a strength for the contractor.

The retinal exam rate for diabetes management showed a dramatic improvement of more than 19 percentage points, from 48.8 percent to 68.0 percent. This amount of improvement was highly statistically significant as well as being of substantive clinical importance. The final rate for the measure was well above the AHCCCS goal of 47 percent. This achievement demonstrates that performance for this measure is a strength for the contractor.

The EPSDT participation rate of 95.0 percent is also considered a strength for the contractor. From the relative perspective of the scores from each of the contractors for this measure, Cochise outperformed the next nearest contractor by 2 percentage points. As an additional point of comparison, the contractor's result also greatly exceeded the AHCCCS goal of 53 percent.

### Performance Measures—CAPs

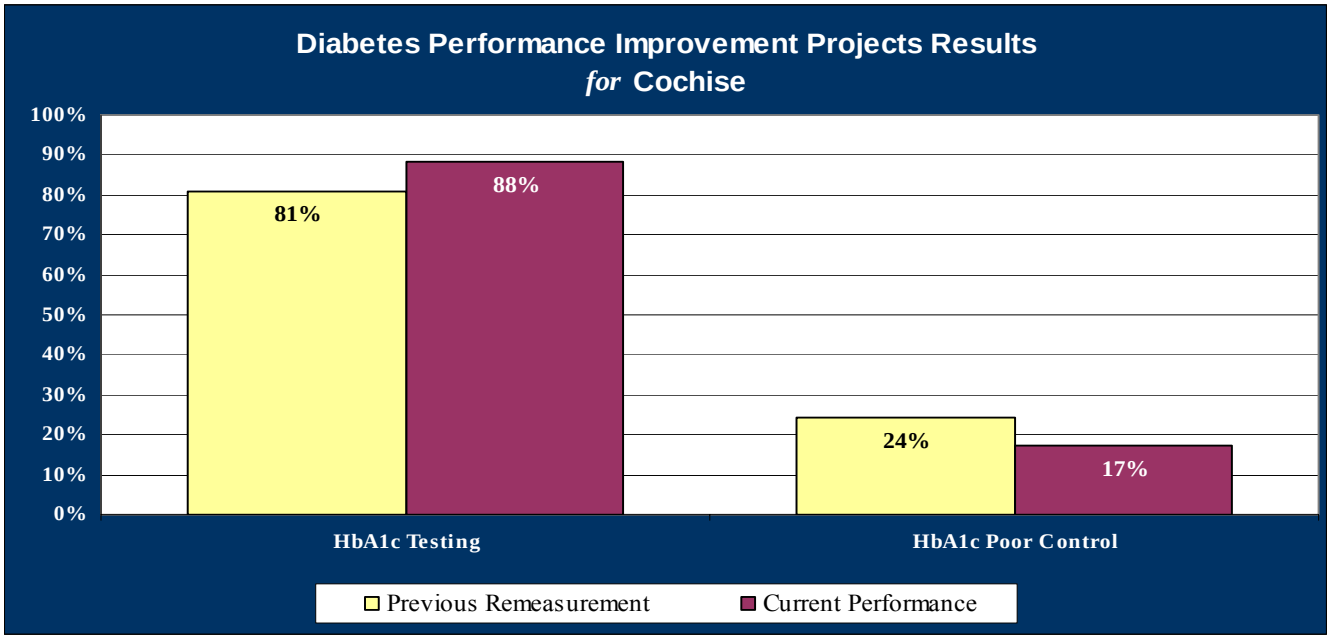
The contractor did not have any required CAPs for the performance measure review during the current review cycle.

## Review of PIPs

Figure 3-3 presents the change in PIP performance for the two most recent measurement periods for Cochise. The figure shows improvement in both measures of diabetes management and control. The contractor's current rate for HbA1c testing is 88 percent, which is functionally equivalent to the 90th percentile from the 2005 national HEDIS Medicaid results of 88.8 percent. The HbA1c poor control rate of 17 percent exceeds the 90th percentile from the 2005 national HEDIS Medicaid results, which is 31.1 percent.[3-7] The rate for HbA1c poor control is a recognized strength for Cochise.

[3-7] The reason that the lower rate of 19 percent exceeds the 90th percentile rate of 31.1 percent is the reversed structure of the measure whereby lower rates are indicative of better performance.

**Figure 3-3—Change in PIP Study Indicator Rates for Cochise**




As part of its final evaluation for the diabetes management PIP, Cochise reported that provider and member education were the most important interventions in increasing compliance with diabetic indicators. Cochise provided education to physicians and providers in the form of memos, diabetic worksheets, diabetic clinical practice recommendations, copies of the AHCCCS minimum performance standards and goals, sample HSAG diabetes flow sheets and progress notes, and sample HSAG "Passport to Better Health." Cochise also conducted follow-up phone calls and letters and notified providers with results from each of the PIP remeasurement periods. The contractor provided education and training to skilled nursing facilities through distributing sample diabetic worksheets and diabetes care plans, and conducted chart reviews with follow-up letters and phone calls. Additional activities included participating in community health fairs and providing free diabetes classes to educate members, families, and the community at large.

A management of comorbid disease PIP was started by the contractors during the current review cycle. Table 3-7 presents the baseline results for this PIP. The table shows that the mean number of inpatient days and the mean number of ER/UC visits were both slightly higher for the contractor than the statewide averages. Further, the mean number of outpatient encounters was lower than the statewide average. Although a causal connection cannot be drawn at this time, the contractor might find that increasing the mean number of outpatient visits/encounters could further decrease the means for the other two measures.

| Table 3-7—Performance Improvement Projects—Comorbid Disease *for* Cochise | | |
|---|---|---|
| **PIP Measure** | **Program contractor Baseline Measure—October 1, 2002–September 30, 2003** | **Statewide Baseline Measure—October 1, 2002–September 30, 2003** |
| Mean Number of Inpatient Days | 16.62 | 15.92 |
| Mean Number of ER/UC Visits | 0.92 | 0.59 |
| Mean Number of Outpatient Encounters | 43.68 | 59.58 |
| Note: The denominator for all three measures is the number of eligible members in the sample frame who reside in their home and have at least two of the specified diseases. | | |

As part of its proposed interventions to manage comorbid/coexisting diseases, Cochise identified the following as some of its strategic interventions: researching and implementing clinical pathways (e.g., chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), osteoporosis, and diabetes); educating providers on clinical pathway guidelines; and implementing medical management chart reviews to ensure that these diseases are managed appropriately.

## *Strengths, Opportunities for Improvement, and Recommendations for Cochise*

The next three sections discuss: (1) findings from AHCCCS' assessment of the sufficiency of the contractors' corrective action plans which were required by AHCCCS as a result of the findings from the prior year's full OFR, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths for the area of review that were found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

### Compliance with Standards (Operational and Financial Review)

#### Strengths

In assessing the sufficiency of the CAPs/associated documentation, AHCCCS determined that for all of the 19 required CAPs, the activities and interventions specified in the CAP/associated documentation: (1) could be reasonably anticipated to correct the identified deficiencies and bring Cochise back into compliance with the AHCCCS standards and/or (2) demonstrated that Cochise had already completed the activities/interventions and was now in compliance with one or more of the standards for which a CAP was required. AHCCCS also approved the Cochise Network Development and Management Plan and commended Cochise on its extensive interactions with outside organizations and its use of the Medical Director in the processes related to network management.

#### Opportunities for Improvement and Recommendations

With no open and continuing CAPs from the 2004-2005 OFR, no opportunities for improvement or recommendations are offered for Cochise for the current review.

## Performance Measure Review

### Strengths

With no required CAPs in this area, the performance measure review is seen as a strength for the contractor. Performance for every measure exceeded the minimum AHCCCS performance standard for the current review cycle. The EPSDT participation rate of 95.0 percent far exceeded the AHCCCS goal of 53 percent. The contactor is recognized for its excellent performance on the measures reviewed.

### Opportunities for Improvement and Recommendations

The absence of any required CAPs suggests that opportunities for improvement and recommendations should be viewed as a lower priority than when CAPs are required. Nonetheless, two of the performance measure rates (i.e., the initiation of HCBS and HbA1c testing) declined between the two most recent measurement cycles, although not by a statistically significant amount. Since the HbA1c testing rate fell more than the rate for the initiation of HCBS and was closer to reaching statistical significance (i.e., $p \leq .05$), the HbA1c testing rate shows more room for improvement than does the initiation of HCBS.

Recommendation: The contractor should consider evaluating whether the current interventions have achieved the maximum gains from those activities. Based on that evaluation, Cochise should strengthen the current interventions or add additional interventions designed to stabilize and continually improve the HbA1c testing and the initiation of HCBS rates.

## Review of PIPs

### Strengths

The rates for the diabetes control measures were among the best in the nation, being functionally equivalent to or exceeding the 90th percentile from the 2005 national HEDIS Medicaid results. Further, substantive continued improvement was suggested by the improvement in rates between the two most recent measurement cycles. The contractor is recognized for its performance improvement processes and results related to this PIP.

### Opportunities for Improvement and Recommendations

As the diabetes management PIP is closed, there are no opportunities for improvement or recommendations offered in the current review cycle for this PIP.

For the comorbid disease PIP, the contractor has submitted a series of proposed interventions to improve its results. The strategies appear to be sound and thoughtfully selected and as having reasonable probability of positively impacting the performance rates.

Recommendation: The contractor should also consider implementing a rapid cycle approach to evaluating the success of the interventions and for modifying them accordingly.

# Evercare Select (Evercare)

## Compliance with AHCCCS' Required Corrective Actions Related to the Standards (Operational and Financial Review)

For Evercare, Table 3-8 presents each of the nine categories of technical standards assessed for the CY 2004–2005 comprehensive OFR, total number of technical standards in each category, number of CAPs required, and number of continuing CY 2005–2006 CAPs for each category.

**Table 3-8—Overview of Total CAPs Required *for* Evercare**

| Categories of Technical Standards | Total Number of Standards CY 2004-2005 | Number of CY 2004–2005 CAPs | Number of Continuing CY 2005–2006 CAPs |
|---|---|---|---|
| Administrative Management | **25** | 3 | 0 |
| Behavioral Health | **8** | 4 | 0 |
| Delivery System | **16** | 0 | 0 |
| Encounters | **15** | 2 | 0 |
| Financial Management | **12** | 1 | 0 |
| Grievance System | **16** | 5 | 0 |
| Case Management | **5** | 1 | 0 |
| Quality Management | **11** | 5 | 0 |
| Utilization Management | **11** | 1 | 1 |
| **Total** | **119** | **22** | **1** |

The CY 2004–2005 review identified one or more standards requiring improvement within most of the categories of technical standards, resulting in 22 required CAPs. In assessing the sufficiency of the CAPs/associated documentation, AHCCCS determined that for all but 1 of the 22 required CAPs, the activities and interventions specified in the CAPs/associated documentation: (1) could be reasonably anticipated to correct the identified deficiencies and bring Evercare back into compliance with the AHCCCS standards and/or (2) demonstrated that Evercare had already completed the activities/interventions and was now in compliance with the one or more of the standards for which a CAP was required. The actions proposed or taken by Evercare to improve its performance included updating policies, procedures, and processes; enhancing provider network monitoring; improving member education; and strengthening staff training. The one CAP/associated documentation that AHCCCS assessed as not yet sufficient and is continuing was for the technical standard UM1.1—"*The Program contractor has written policies and procedures for utilization management program requirements which are consistent with AHCCCS standards.*"

## Performance Measure Review

Table 3-9 presents the performance measure rates for Evercare. The table shows the following: the previous performance, the current performance, the relative percentage change, the statistical

significance of the change, the CYE 2005 minimum AHCCCS performance standard, the AHCCCS goal, and the AHCCCS long-range benchmark.

**Table 3-9—Performance Measurement Review *for* Evercare**

| Performance Measure | Actual Performance for Oct. 1, 2003 to Sept. 30, 2004 | Actual Performance for Oct. 1, 2004 to Sept. 30, 2005 | Relative Percent Change | Significance Level* | CYE 2005 Minimum AHCCCS Performance Standard | AHCCCS Goal | AHCCCS Long-Range Benchmark |
|---|---|---|---|---|---|---|---|
| Initiation of HCBS** | 85.4% | 90.0% | 5.4% | p=.412 | 84% | 85% | 98% |
| Diabetes Management—HbA1c Testing | 60.9% | 69.3% | 13.9% | p=.078 | 75% | 77% | 85% |
| Diabetes Management—Lipid Screening | 63.6% | 66.5% | 4.6% | p=.541 | 76% | 78% | 81% |
| Diabetes Management—Retinal Exams | 50.5% | 85.6% | 69.3% | p<.001 | 45% | 47% | 64% |
| EPSDT Participation | N/A | 58.0% | N/A | N/A | 50% | 53% | 80% |

Notes:

*Significance Levels (p-value) noted in the table were performed by AHCCCS and demonstrate the statistical significance between the performance for the previous remeasurement period and actual performance for the current period. Statistical significance is traditionally reached when the p-value ≤ .05.

**HCBS is Home and Community-Based Services.

N/A is shown because EPSDT participation rates were newly reported for CYE 2006.

Table 3-9 shows improved performance for the contractor for all four measures with comparable rates, although only the rate for the Retinal Exam measure improved by a statistically significant amount (i.e., $p \leq .05$). The initiation of HCBS rate improved by a relative 5.4 percent, but the gain was not statistically significant. The final rate of 90.0 percent was, however, above the AHCCCS goal of 85 percent; therefore, this measure is considered a strength for the contractor.

The HbA1c testing rate for diabetes management improved a relative 13.9 percent between measurement periods, but the amount was not statistically significant. The final rate of 69.3 percent was below the minimum AHCCCS performance standard of 75 percent. This measure is, therefore, considered an opportunity for improvement.

The rate for diabetes management—lipid screening improved by a relative 4.6 percent between the two most recent measurement periods. This amount of improvement was not statistically significant. The final rate of 66.5 percent was also below the minimum AHCCCS performance standard of 76 percent and, as a result, this measure also is considered an opportunity for improvement.

The rate for diabetes management—retinal exam showed a dramatic improvement of more than 35 percentage points, from 50.5 percent to 85.6 percent. This amount of improvement was highly statistically significant as well as being of substantive clinical importance. The final rate for the measure was well above the AHCCCS goal of 47 percent. This achievement demonstrates that performance for this measure is an unqualified strength for Evercare.

The EPSDT participation rate of 58.0 percent was above the AHCCCS goal of 53 percent. The contractor is recognized for its achievement during this first reporting cycle.

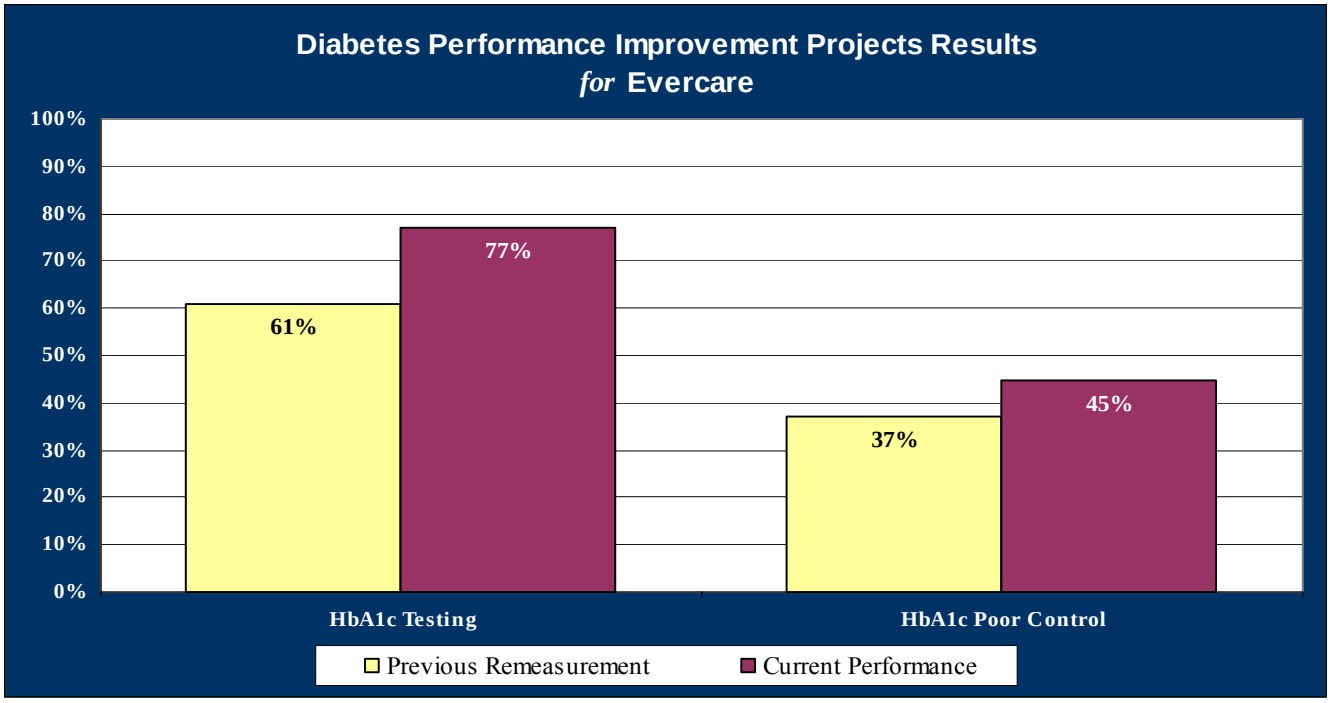
## Performance Measures—CAPs

The contractor had two required CAPs for its performance measures. Both measures were for diabetes management—HbA1c testing and lipid screening. The rates for both measures were below both the AHCCCS minimum required standard and the 25th percentile from the 2005 national HEDIS Medicaid results

## *Review of PIPs*

AHCCCS closed the diabetes management PIP in 2006 for all contractors, except for Evercare. Evercare had not yet demonstrated significant and sustained improvement in previous remeasurement cycles and was asked to participate in a third remeasurement. Figure 3-4 presents the change in performance for the PIP for the two most recent measurement periods, CYE 2004 and CYE 2005, respectively. The figure shows mixed performance, with improvement in the HbA1c testing rate and a decline in the HbA1c poor control rate. The contractor's current rate for HbA1c testing is 77 percent, which is somewhat below the 50th percentile from the 2005 national HEDIS Medicaid results of 78.4 percent. The HbA1c poor control rate of 45 percent is just slightly above the 50th percentile from the 2005 national HEDIS Medicaid results of 47.5 percent.[3-8]

**Figure 3-4—Change in PIP Study Indicator Rates for Evercare**




[3-8] The reason that the lower rate of 45 percent is better than the 50th percentile rate of 47.5 percent is the reversed structure of the measure whereby lower rates are indicative of better performance.

As part of its summary evaluation of performance for the diabetes management PIP, Evercare reported that it will continue to train its case managers to properly document lab values and dates in the contractor's information system and distribute educational packets to all members with a diabetes diagnosis. The educational packet included: a letter explaining the diabetes management program, information on glucometers, an educational pamphlet—*Living with Diabetes*, a log for tracking blood sugar levels, and a number of other educational pamphlets (e.g., *Know Your Blood Sugar Numbers*, *Diabetic Foot Care*, *Diabetes and Exercise,* and *Blood Glucose Self-Monitoring*). In addition to providing the educational materials, Evercare case managers contacted the members' primary care providers (PCPs) to verify that the PCPa had obtained HbA1c testing within the past six months.

A PIP addressing the management of comorbid disease was started by the contractors during the current review cycle. Table 3-10 presents the baseline results for this PIP. The table shows that the mean number of inpatient days and the mean number of outpatient encounters were both higher than the statewide averages, while the mean number of ER/UC visits was somewhat lower. It seems reasonable to predict that more outpatient visits/encounters would be associated with fewer inpatient days and ER/UC visits. The results will be reviewed again in the next reporting cycle.

**Table 3-10—Performance Improvement Projects—Comorbid Disease *for* Evercare**

| PIP Measure | Program contractor Baseline Measure—October 1, 2002–September 30, 2003 | Statewide Baseline Measure—October 1, 2002–September 30, 2003 |
|---|---|---|
| Mean Number of Inpatient Days | 21.16 | 15.92 |
| Mean Number of ER/UC Visits | 0.46 | 0.59 |
| Mean Number of Outpatient Encounters | 82.17 | 59.58 |

Note: The denominator for all three measures is the number of eligible members in the sample frame who reside in their home and have at least two of the specified diseases.

As part of its review of this PIP, Evercare identified a key barrier in addressing the needs of members. Specifically, case managers were not being notified, by either the member or caregiver, of member hospitalizations. In order to overcome barriers to improving the performance for this measure, Evercare reported having implemented interventions to reduce acute care utilization and improve care coordination of high-risk members. These strategies included having the utilization review staff notify case managers of requests for hospitalization, conducting case reviews with the Medical Director to identify treatment alternatives, implementing a post hospitalization care coordination program—Welcome Home, and using telemonitoring as part of the management of members with congestive heart failure. Based on its review of data, Evercare reported that possible future interventions could include strengthening the chronic disease management program for diabetes, with an emphasis on the Hispanic population; focusing on the behavioral health services; increasing case manager awareness of various diseases; providing education on management of signs and symptoms for comorbid diseases; increasing case managers' coordination activities with the providers; and intensifying care management education related to behavioral health conditions.

## Strengths, Opportunities for Improvement, and Recommendations for Evercare

The next three sections discuss: (1) findings from AHCCCS' assessment of the sufficiency of Evercare's CAPs/associated documentation which were required by AHCCCS as a result of the findings from the prior year full OFR, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths for the area of review that were found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

### Compliance with Standards (Operational and Financial Review)

#### Strengths

AHCCCS determined that for all but 1 of the 22 required CAPs, the activities and interventions specified in the CAPs/associated documentation: (1) could be reasonably anticipated to correct the identified deficiencies and bring Evercare back into compliance with the AHCCCS standards and/or (2) demonstrated that Evercare had already completed the activities/interventions and was now in compliance with the one or more of the standards for which a CAP was required. AHCCCS also approved the Evercare Network Development and Management Plan and commended Evercare on its analysis of the current network and its ambitious goals for CYE 2006.

#### Opportunities for Improvement and Recommendations

The one CAP/associated documentation that AHCCCS assessed as not yet sufficient and is continuing was for the technical standard UM1.1—*The Program contractor has written policies and procedures for utilization management program requirements which are consistent with AHCCCS standards*.

Recommendations: Given that the standard requires the contractor to have policies and procedures that are consistent with AHCCCS policies, Evercare should consider conducting a rigorous and detailed side-by-side comparison of its utilization management policies and procedures to the current AHCCCS policies and procedures to identify any gaps or areas that are inconsistent with AHCCCS'. If not already operational, Evercare should consider developing a process and accountabilities for ensuring that its policies and procedures are reviewed and, as applicable, revised any time the AHCCCS contract and/or policies/procedures or requirements in other binding documents change, in order to ensure that the Evercare policies and procedures remain consistent with the most current AHCCCS requirements.

### Performance Measure Review

#### Strengths

Ensuring timely retinal exams as part of diabetes management is a definite strength for the contractor. At 85.6 percent, Evercare's performance considerably exceeded the AHCCCS goal of 47 percent.

The initiation of HCBS rate of 90.0 percent is above the AHCCCS goal of 85 percent and is also considered a strength for Evercare.

## Opportunities for Improvement and Recommendations

The contractor had two required CAPs related to performance measures. Both measures (HbA1c testing and lipid screening) were in the area of diabetes management. The rates for both measures were below the 25th percentile from the 2005 national HEDIS Medicaid results and below the minimum AHCCCS required standard.

Recommendation: Evercare should consider (1) conducting a root cause analysis of the factors contributing to the failure to perform at or above the minimum required levels, looking at such things as any changes that may have purposefully or inadvertently occurred in the current intervention strategies or other intervening variables and making any needed adjustments; and/or (2) drawing on the best practice experiences of other contractors who have been more successful in their performance for these measures and based on their experience, revise or add to the current interventions. In addition, the contractor should consider adding or enhancing the provider capacity to draw the needed blood samples during routine PCP visits as a potential means of removing any barrier to access if members have to schedule a second appointment and, at times, at a different location (i.e., testing/laboratory site).

## Review of PIPs

## Strengths

After a third remeasurement cycle the diabetes management PIP was successfully conducted and closed for this contractor. Nonetheless, the contractor's final rates approximated only the 50th percentiles from the 2005 national HEDIS Medicaid results. For this reason, the diabetes PIP is considered a qualified success.

## Opportunities for Improvement and Recommendations

As the diabetes management PIP is closed, there are no opportunities for improvement or recommendations offered in the current review cycle for this PIP. For the comorbid disease PIP, the contractor submitted a number of proposed interventions to improve its results. The proposed interventions appear sound and to have reasonable probability of positively impacting performance.

Recommendation: The contractor should also consider initiating a rapid cycle approach to monitoring performance and evaluating the success of the proposed interventions and for modifying them accordingly.

# Mercy Care Plan (Mercy Care)

## Compliance with AHCCCS' Required Corrective Actions Related to the Standards (Operational and Financial Review)

For Mercy Care, Table 3-11 presents each of the nine categories of technical standards assessed for the CY 2004–2005 comprehensive OFR, total number of technical standards in each category, number of CAPs required, and number of continuing CY 2005–2006 CAPs for each category.

**Table 3-11—Overview of Total CAPs Required *for* Mercy Care**

| Categories of Technical Standards | Total Number of Standards CY 2004-2005 | Number of CY 2004–2005 CAPs | Number of Continuing CY 2005–2006 CAPs |
|---|---|---|---|
| Administrative Management | **25** | 3 | 0 |
| Behavioral Health | **8** | 3 | 0 |
| Delivery System | **16** | 0 | 0 |
| Encounters | **15** | 0 | 0 |
| Financial Management | **12** | 2 | 0 |
| Grievance System | **16** | 6 | 0 |
| Case Management | **5** | 1 | 0 |
| Quality Management | **11** | 5 | 0 |
| Utilization Management | **11** | 4 | 0 |
| **Total** | **119** | **24** | **0** |

The CY 2004–2005 review identified one or more standards within most of the categories reviewed that resulted in required CAPs. In assessing the sufficiency of the CAPs/associated documentation, AHCCCS determined that for all 24 required CAPs, the activities and interventions specified in the CAPs/associated documentation: (1) could be reasonably anticipated to correct the identified deficiencies and bring Mercy Care back into compliance with the AHCCCS standards and/or (2) demonstrated that Mercy Care had already completed the activities/interventions and was now in compliance with the one or more of the standards for which a CAP was required. Mercy Care's improvement activities included updating policies, procedures, and processes; enhancing member education and outreach; improving staff training; and enhancing performance improvement reporting.

## Performance Measure Review

Table 3-12 presents the performance measure rates for Mercy Care. The table shows the following: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, the CYE 2005 minimum AHCCCS performance standard, the AHCCCS goal, and the AHCCCS long-range benchmark.

| Table 3-12—Performance Measurement Review *for* Mercy Care | | | | | | | |
|---|---|---|---|---|---|---|---|
| Performance Measure | Actual Performance for Oct. 1, 2003 to Sept. 30, 2004 | Actual Performance for Oct. 1, 2004 to Sept. 30, 2005 | Relative Percent Change | Significance Level* | CYE 2005 Minimum AHCCCS Performance Standard | AHCCCS Goal | AHCCCS Long-Range Benchmark |
| Initiation of HCBS** | 85.5% | 85.6% | 0.1% | p=.971 | 84% | 85% | 98% |
| Diabetes Management—HbA1c Testing | 76.9% | 77.1% | 0.3% | p=.944 | 75% | 77% | 85% |
| Diabetes Management—Lipid Screening | 70.3% | 78.6% | 11.8% | p=.033 | 76% | 78% | 81% |
| Diabetes Management—Retinal Exams | 53.3% | 51.7% | -3.0% | p=.719 | 45% | 47% | 64% |
| EPSDT Participation | N/A | 46.0% | N/A | N/A | 50% | 53% | 80% |

Notes:

*Significance Levels (p-value) noted in the table were performed by AHCCCS and demonstrate the statistical significance between the performance for the previous remeasurement period and actual performance for the current period. Statistical significance is traditionally reached when the p-value ≤ .05.

**HCBS is Home and Community-Based Services.

N/A is shown because EPSDT participation rates were newly reported for CYE 2006.

Table 3-12 shows improved performance for the contractor for three of the four measures with comparable rates, although only the improvement for the lipid screening rate reached statistical significance (i.e., $p \leq .05$). The initiation of HCBS rate was practically unchanged, improving by a relative 0.1 percent which was not a statistically significant amount. The final rate of 85.6 percent slightly exceeded the AHCCCS goal of 85 percent. This measure is, therefore, considered a strength for the contractor.

The rate for the HbA1c testing measure for diabetes management was also flat, improving by a relative 0.3 percent between measurement periods. This small amount was not statistically significant. The final rate of 77.1 percent also slightly exceeded the AHCCCS goal of 77 percent. This measure is, therefore, also considered a strength for the contractor.

Between the two most recent measurement periods, the lipid screening rate for diabetes management improved by a relative 11.8 percent, which is a statistically significant amount. The final rate of 78.6 percent was above the minimum AHCCCS performance standard of 76 percent. This measure is, therefore, considered a strength for the contractor. The retinal exam rate for diabetes management showed a small decline, from 53.3 percent to 51.7 percent. This amount of decline was not statistically significant. The final rate for the measure was above the AHCCCS goal of 47 percent. This measure is, therefore, considered a strength for the contractor.

The EPSDT participation rate of 46.0 percent was below the minimum AHCCCS performance standard and, as a result, this measure is seen as an opportunity for improvement.

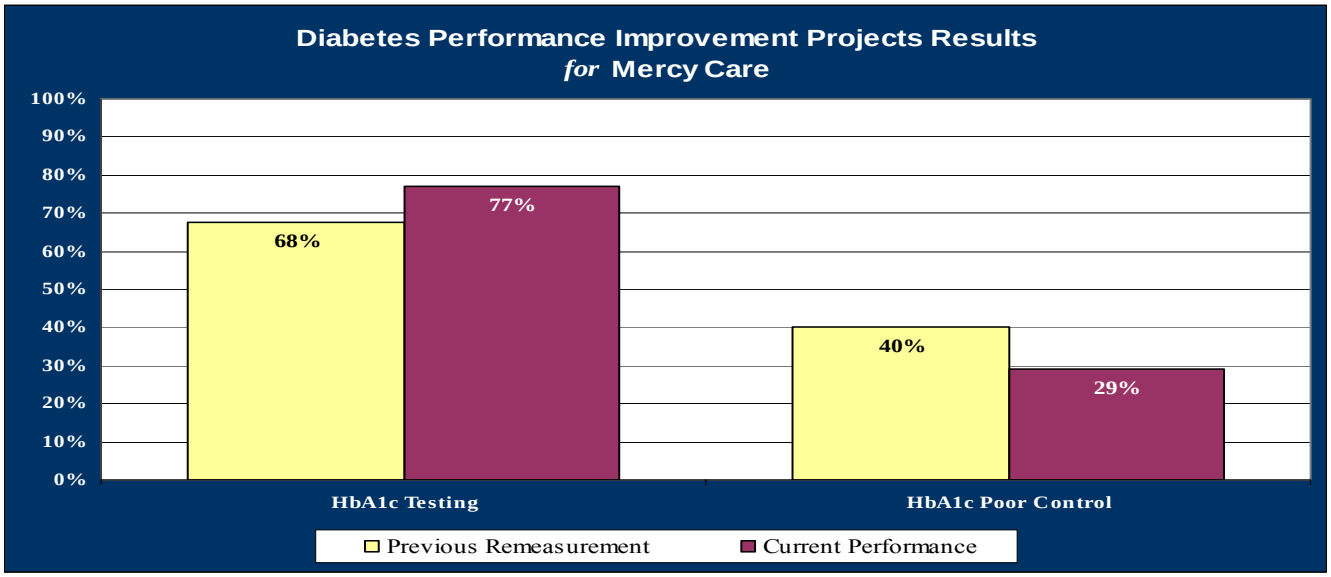
## Performance Measures—CAPs

The contractor had one required CAP (i.e., EPSDT participation rate) from the performance measure review. As this is the first year of reporting this measure, next year's report will show comparative data and any results of implementing the CAP from this year.

## *Review of PIPs*

Figure 3-5 presents the change in PIP performance for the two most recent measurement periods. The figure shows improvement for both measures of diabetes management and control. The contractor's current rate for HbA1c testing is 77 percent, somewhat below the 50th percentile from the 2005 national HEDIS Medicaid results of 78.4 percent. The HbA1c poor control rate of 29 percent is just slightly better than the 90th percentile from the 2005 national HEDIS Medicaid results of 31.1 percent.[3-9] The rate for HbA1c poor control is a recognized strength for the contractor.

**Figure 3-5—Change in PIP Study Indicator Rates for Mercy Care**




As part of its final evaluation for the diabetes management PIP, Mercy Care reported that the improvement occurred during the course of Mercy Care's member and provider-level interventions and extensive case management interventions. The case management interventions were designed to ensure that diabetic members consistently received needed care. Efforts included stratifying members into high, medium, and low risk categories. Targeted member interventions—such as educational mailings, assigning nurse case managers, telephone education, and referral to diabetes education programs—corresponded to the stratified level of risk for each member. Additionally, Mercy Care implemented quarterly provider reports listing diabetic members missing HbA1c tests, lipid screenings, or retinal eye examinations. Mercy Care reported that anecdotal feedback from providers indicated the reports were well received and assisted them in ensuring that diabetic members received appropriate diabetes-related services.

[3-9] The reason that the lower rate of 29 percent is better than the 90th percentile rate of 31.1 percent is the reversed structure of the measure whereby lower rates are indicative of better performance.

A PIP related to the management of comorbid disease was started by the contractors during the current review cycle. Table 3-13 presents the baseline results for this PIP. The table shows all three of the PIP measures were lower than the statewide averages. The next review cycle will update the progress of this PIP.

**Table 3-13—Performance Improvement Projects—Comorbid Disease *for* Mercy Care**

| PIP Measure | Program contractor Baseline Measure—October 1, 2002–September 30, 2003 | Statewide Baseline Measure—October 1, 2002–September 30, 2003 |
|---|---|---|
| Mean Number of Inpatient Days | 12.41 | 15.92 |
| Mean Number of ER/UC Visits | 0.45 | 0.59 |
| Mean Number of Outpatient Encounters | 43.77 | 59.58 |

Note: The denominator for all three measures is the number of eligible members in the sample frame who reside in their home and have at least two of the specified diseases.

As part of its improvement activities to more effectively manage comorbid/coexisting disease, Mercy Care identified the following interventions: case management visits to enhance coordination—each member was visited every 90 days to more comprehensively assess member needs; member education and self-management—case managers offered patient education and self-management skills to manage many problematic coexisting conditions; education on lifestyle modification and/or assistance in care coordination—members were educated on describing their conditions to PCPs; enhanced provider communication; mental health status assessments; continued use of case management software that allowed storage and retrieval of pertinent member information; and assignment of nurse case managers for high-risk members.

## *Strengths, Opportunities for Improvement, and Recommendations for Mercy Care*

The next three sections discuss: (1) findings from AHCCCS' assessment of the sufficiency of the contractor's CAPS which were required by AHCCCS as a result of the findings from the prior year's full OFR, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths for the area of review that were found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

### Compliance with Standards (Operational and Financial Review)

### Strengths

In assessing the sufficiency of the CAPs/associated documentation, AHCCCS determined that for all 24 required CAPs, the activities and interventions specified in the CAPs/associated documentation: (1) could be reasonably anticipated to correct the identified deficiencies and bring Mercy Care back into compliance with the AHCCCS standards and/or (2) demonstrated that Mercy Care had already completed the activities/interventions and was now in compliance with the one or more of the standards for which a CAP was required. AHCCCS also approved the Mercy Care Network Development and Management Plan and commended the contractor on its extensive analysis of the network, efforts in network development for the ALTCS members with behavioral health service needs, and use of the Mercy Care Web site to inform members about the network.

### Opportunities for Improvement and Recommendations

With no open and continuing CAPs remaining from the 2004-2005 OFR, no opportunities for improvement or recommendations are offered for Mercy Care for the current review.

## Performance Measure Review

### Strengths

Given that only the new performance measure (i.e., EPSDT participation) required a CAP, overall performance on the measures is an area of moderate strength for Mercy Care. Rates for every other performance measure exceeded the minimum AHCCCS performance standard for the current review cycle.

### Opportunities for Improvement and Recommendations

The single required CAP indicates an opportunity for improvement in the EPSDT participation rate.

Recommendation: Mercy Care should consider evaluating whether the current interventions are broad enough in number, scope, and target areas to bring about the desired increase in performance and, based on the outcome of the evaluation, should consider strengthening the current interventions and/or adding additional strategies to improve the rates.

While remaining above the AHCCCS minimum performance standard, the rate for retinal exams declined somewhat between measurement periods. The decline, however, was not statistically significant.

Recommendation: The contractor should consider enhancing the frequency of measurement and determine if the decline is continuing. If determined to be continuing, the contractor should consider, as for the above measure, evaluating whether the current interventions are broad enough in number, scope, and target areas to reverse the decline in performance. Based on the results of the evaluation, Mercy Care also should consider strengthening the current interventions and/or adding additional strategies to regain the loss in performance and to continue to increase the performance rates.

The rates for the initiation of HCBS and for HbA1c testing were also flat and did not evidence statistically significant improvement. Overall, while performance exceeded the State's minimum expectations, there is still an opportunity for continued improvement for these measures.

## Review of PIPS

### Strengths

The diabetes management PIP was successfully conducted and closed. The final rates approximated the 50th and 90th percentiles from the 2005 national HEDIS Medicaid results for HbA1c testing and lipid screening, respectively. Mercy Care's performance for the diabetes management is considered a strength.

## Opportunities for Improvement and Recommendations

Based on the strength of performance and the fact that the diabetes management PIP is closed, there are no opportunities for improvement or recommendations offered in the current review cycle for the Mercy Care diabetes PIP.

For the comorbid disease PIP, the contractor has submitted a series of proposed interventions to improve its results. The strategies appear to be sound and thoughtfully selected and as having reasonable probability of positively impacting the performance rates.

Recommendation: The contractor should also consider implementing a rapid cycle approach to evaluating the success of the interventions and for modifying them accordingly.

# Pima Health System (Pima)

## Compliance with AHCCCS' Required Corrective Actions Related to the Standards (Operational and Financial Review)

For Pima, Table 3-14 presents each of the nine categories of technical standards assessed for the CY 2004–2005 comprehensive OFR, total number of technical standards in each category, number of CAPs required, and number of continuing CY 2005–2006 CAPs for each category.

**Table 3-14—Overview of Total CAPs Required *for* Pima**

| Categories of Technical Standards | Total Number of Standards CY 2004-2005 | Number of CY 2004–2005 CAPs | Number of Continuing CY 2005–2006 CAPs |
|---|---|---|---|
| Administrative Management | **25** | 4 | 0 |
| Behavioral Health | **8** | 2 | 0 |
| Delivery System | **16** | 0 | 0 |
| Encounters | **15** | 2 | 0 |
| Financial Management | **12** | 2 | 0 |
| Grievance System | **16** | 0 | 0 |
| Case Management | **5** | 0 | 0 |
| Quality Management | **11** | 0 | 0 |
| Utilization Management | **11** | 5 | 0 |
| **Total** | **119** | **15** | **0** |

The CY 2004–2005 review identified one or more standards requiring improvement within five of the nine categories. In assessing the sufficiency of the CAPs/associated documentation, AHCCCS determined that for all of the 15 required CAPs, the activities and interventions specified in the CAPs/associated documentation: (1) could be reasonably anticipated to correct the identified deficiencies and bring Pima back into compliance with the AHCCCS standards and/or (2) demonstrated that Pima had already completed the activities/interventions and was now in compliance with the one or more of the standards for which a CAP was required.

The contractor's improvement activities included revising and strengthening policies, procedures, and processes; enhancing member education; and improving encounter management.

## Performance Measure Review

Table 3-15 presents the performance measure rates for the contractor. The table shows the following: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, the CYE 2005 minimum AHCCCS performance standard, the AHCCCS goal, and the AHCCCS long-range benchmark.

| Table 3-15—Performance Measurement Review *for* Pima | | | | | | | |
|---|---|---|---|---|---|---|---|
| Performance Measure | Actual Performance for Oct. 1, 2003 to Sept. 30, 2004 | Actual Performance for Oct. 1, 2004 to Sept. 30, 2005 | Relative Percent Change | Significance Level* | CYE 2005 Minimum AHCCCS Performance Standard | AHCCCS Goal | AHCCCS Long-Range Benchmark |
| Initiation of HCBS** | 96.7% | 91.9% | -5.0% | p=.207 | 84% | 85% | 98% |
| Diabetes Management—HbA1c Testing | 75.5% | 70.6% | -6.5% | p=.245 | 75% | 77% | 85% |
| Diabetes Management—Lipid Screening | 74.1% | 75.3% | 1.7% | p=.759 | 76% | 78% | 81% |
| Diabetes Management—Retinal Exams | 31.1% | 61.9% | 98.8% | p<.001 | 45% | 47% | 64% |
| EPSDT Participation | N/A | 65.0% | N/A | N/A | 50% | 53% | 80% |

Notes:

*Significance Levels (p-value) noted in the table were performed by AHCCCS and demonstrate the statistical significance between the performance for the previous remeasurement period and actual performance for the current period. Statistical significance is traditionally reached when the p-value ≤ .05.

**HCBS is Home and Community-Based Services.

N/A is shown because EPSDT participation rates were newly reported for CYE 2006.

Table 3-15 shows mixed performance for the contractor, as the rates for two of the measures improved and two declined. The rate for retinal exams measure was the only rate that changed by a statistically significant amount (i.e., $p \leq .05$). The rate for initiation of HCBS declined somewhat, but the amount was not statistically significant. The final rate of 91.9 percent was above the AHCCCS goal of 85 percent. This measure is considered a strength for the contractor.

The HbA1c testing rate for diabetes management declined by a relative 6.5 percent between measurement periods, but the amount was not statistically significant. The final rate of 70.6 percent was, however, below the minimum AHCCCS performance standard of 75 percent. This measure is assessed to be a high-priority opportunity for improvement.

The rate for the lipid screening measure improved by a relative 1.7 percent between the two most recent measurement periods. This amount of improvement was not statistically significant. The final rate of 75.3 percent was just below the minimum AHCCCS performance standard of 76 percent and is, therefore, also considered an opportunity for improvement.

The retinal exams measure for diabetes management showed a dramatic improvement of more than 30 percentage points, from 31.1 percent to 61.9 percent, which is a relative improvement of 98.8 percent. This amount of improvement was highly statistically significant, as well as being of substantive clinical importance. The final rate for the measure was well above the AHCCCS goal of 47 percent. This achievement demonstrates a notable strength for the contractor.

The EPSDT participation rate of 65.0 percent is also a strength for the contractor. The rate exceeded both the minimum AHCCCS performance standard and the AHCCCS goal.

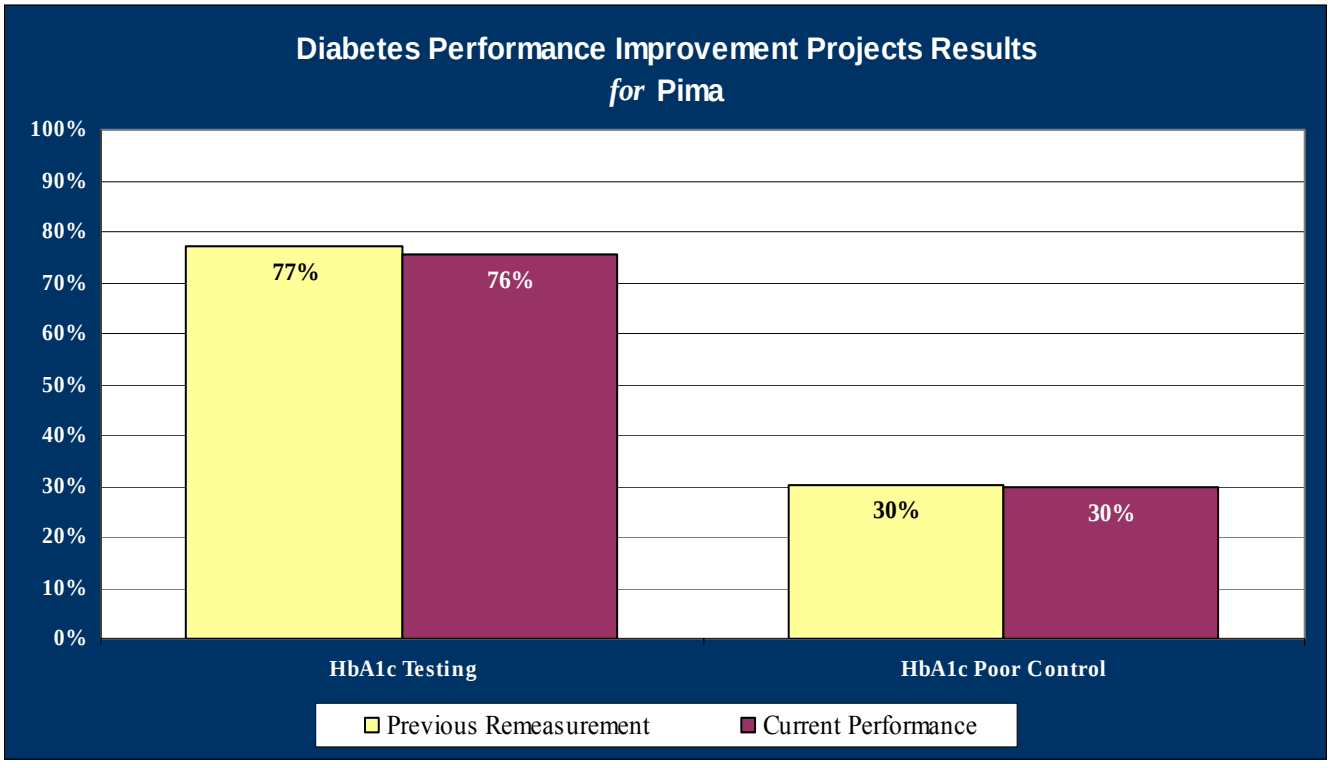
## Performance Measures—CAPs

The contractor had two required CAPs for the performance measure review. Both measures were related to diabetes management (i.e., HbA1c testing and lipid testing). The rates for both measures were below the AHCCCS minimum required levels and approximated the 25th percentile from the 2005 HEDIS Medicaid results.

## *Review of PIPs*

Figure 3-6 presents the change in PIP performance for the two most recent measurement periods. The figure shows mixed improvement and essentially flat results for both measures of diabetes management and control. The current contractor's rate for HbA1c testing is 76 percent, somewhat below the 50th percentile from the 2005 national HEDIS Medicaid results of 78.4 percent. The HbA1c poor control rate of 30 percent is just slightly better than the 90th percentile from the 2005 national HEDIS Medicaid results of 31.1 percent.[3-10] The rate for HbA1c poor control is a recognized strength for the contractor.

**Figure 3-6—Change in PIP Study Indicator Rates for Pima**




As part of its final evaluation for the diabetes management PIP, Pima reported that the success of its PIP performance was considered to be due to a number of interventions implemented by Pima to more effectively manage its diabetic members. Pima plans to continue using the following

[3-10] The reason that the lower rate of 30 percent is better than the 90th percentile rate of 31.1 percent is the reversed structure of the measure whereby lower rates are indicative of better performance.

interventions: including informational articles in provider and member newsletters; conducting a special mailing to members in November of each year; having the Pharmacy Division notify PCPs in writing of members who are noncompliant with their diabetic medication refills, as reflected by the available pharmacy data; referring members to diabetes education programs; monitoring HbA1c lab test reports; and reporting HbA1c lab test results to the Quality Management/Performance Improvement (QM/PI) Committee to address ongoing performance improvement on the measure.

A PIP focused on the management of comorbid disease was started by the contractors during the current review cycle. Table 3-16 presents the baseline results for this PIP. The table shows that the mean number of inpatient days and the mean number of ER/UC visits were both slightly higher for the contractor than the statewide averages. The mean number of outpatient encounters was lower than the statewide average. Although a causal connection cannot be drawn at this time, the contractor might find that increasing the mean number of outpatient services/encounters could further decrease the means for the other two indicators.

**Table 3-16—Performance Improvement Projects—Comorbid Disease *for* Pima**

| PIP Measure | Program contractor Baseline Measure—October 1, 2002–September 30, 2003 | Statewide Baseline Measure—October 1, 2002–September 30, 2003 |
|---|---|---|
| Mean Number of Inpatient Days | 20.88 | 15.92 |
| Mean Number of ER/UC Visits | 0.93 | 0.59 |
| Mean Number of Outpatient Encounters | 42.17 | 59.58 |

Note: The denominator for all three measures is the number of eligible members in the sample frame who reside in their home and have at least two of the specified diseases.

Pima reported its continued commitment to work with AHCCCS to prevent the onset of additional comorbid diseases. Pima implemented the following interventions to improve the rates for management of coexisting diseases: providing in-service training for case management supervisors about the purpose and value of the study, training case managers on the purpose of the study and the need for them to educate members on proper use of the emergency room, publishing articles in the provider newsletter, and linking members who overused emergency department services to the assigned PCP to provide additional education about the appropriate use of the emergency room.

## *Strengths, Opportunities for Improvement, and Recommendations for Pima*

The next three sections discuss: (1) findings from AHCCCS' assessment of the sufficiency of the contractor's CAPS which were required by AHCCCS as a result of the findings from the prior year's full OFR, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths for the area of review that were found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

## Compliance with Standards (Operational and Financial Review)

### Strengths

In assessing the sufficiency of the CAPs/associated documentation, AHCCCS determined that for all of the 15 required CAPs, the activities and interventions specified in the CAPs/associated documentation: (1) could be reasonably anticipated to correct the identified deficiencies and bring Pima back into compliance with the AHCCCS standards and/or (2) demonstrated that Pima had already completed the activities/interventions and was now in compliance with the one or more of the standards for which a CAP was required.

AHCCCS also approved the Pima Network Development and Management Plan and commended Pima on its detailed and impressive analysis of current and future network needs. AHCCCS also expressed commendation for Pima having included the following elements in the network plans: historical and legal information on the Medicaid program; Pima internal policy references documenting established procedures related to network management; information on other provider standards on which some of the network analysis was based; and information addressing business continuation plans, provider communications, and cultural competency.

### Opportunities for Improvement and Recommendations

With no open and continuing CAPs remaining from the 2004-2005 OFR, no opportunities for improvement or recommendations are offered for Pima for the current review.

## Performance Measure Review

### Strengths

The contractor's performance results for the initiation of HCBS, provision of retinal exams in diabetes management, and EPSDT participation are significant strengths for Pima. Not only did the rate for these measures exceed the minimum AHCCCS performance standard, the rates also exceeded the AHCCCS goals.

### Opportunities for Improvement and Recommendations

The contractor had two required CAPs related to the performance measures. Both measures (i.e., HbA1c testing and lipid screening) were related to diabetes management. The rates for both measures were below the minimum AHCCCS required rates and approximated the 25th percentile from the 2005 national HEDIS Medicaid results.

Recommendation: The contractor should consider evaluating whether the current interventions are broad enough in number, scope, and areas targeted to bring about the desired increase in performance rates. Based on the outcome of the evaluation, Pima should strengthen the current strategies and/or add additional interventions. If not currently doing so, the program contract should consider evaluating the availability of testing/screening that can be performed at the same time and in the same location as routine PCP office visits and evaluate the probable impact of increasing this availability as one potential way to decrease any barriers to obtaining the testing. In addition, the contractor should consider evaluating whether provider and member informational materials are

sufficient in frequency and content to compel provider compliance and reduce member resistance to the testing. If not currently in place, the contractor may also want to consider implementing a system of provider incentives and sanctions/withholds related to performance and member incentives for obtaining the needed tests/screenings.

## Review of PIPS

### Strengths

The diabetes management PIP was successfully conducted and closed. The final rates approximated the 50th and 90th percentiles from the 2005 national HEDIS Medicaid results for HbA1c testing and lipid screening, respectively. The contractor's performance for the diabetes management PIP is considered a strength.

### Opportunities for Improvement and Recommendations

Due to the diabetes management PIP being closed, there are no opportunities for improvement or recommendations offered in the current review cycle for the PIP. For the comorbid disease PIP, the contractor has submitted a series of proposed interventions to improve its results. The interventions that the contractor described appear to have been thoughtfully selected and focused, and to be reasonable and sound as strategies for improving performance.

Recommendation: The contractor should also consider implementing a rapid cycle approach to evaluating the success of the interventions and for modifying them accordingly.

# Pinal/Gila Long Term Care (Pinal/Gila)

## *Compliance with AHCCCS' Required Corrective Actions Related to the Standards (Operational and Financial Review)*

For Pinal/Gila, Table 3-17 presents each of the nine categories of technical standards assessed for the CY 2004–2005 comprehensive OFR, total number of technical standards in each category, number of CAPs required, and number of continuing CY 2005–2006 CAPs for each category.

**Table 3-17—Overview of Total CAPs Required *for* Pinal/Gila**

| Categories of Technical Standards | Total Number of Standards CY 2004-2005 | Number of CY 2004–2005 CAPs | Number of Continuing CY 2005–2006 CAPs |
|---|---|---|---|
| Administrative Management | **25** | 4 | 0 |
| Behavioral Health | **8** | 0 | 0 |
| Delivery System | **16** | 2 | 0 |
| Encounters | **15** | 1 | 0 |
| Financial Management | **12** | 0 | 0 |
| Grievance System | **16** | 3 | 0 |
| Case Management | **5** | 0 | 0 |
| Quality Management | **11** | 4 | 0 |
| Utilization Management | **11** | 2 | 0 |
| **Total** | **119** | **16** | **0** |

The CY 2004–2005 review identified one or more standards requiring performance improvement within several of the categories of standards. In assessing the sufficiency of the CAPs/associated documentation, AHCCCS determined that for all 16 of the required CAPs, the activities and interventions specified in the CAPs/associated documentation: (1) could be reasonably anticipated to correct the identified deficiencies and bring Pinal/Gila back into compliance with the AHCCCS standards and/or (2) demonstrated that Pinal/Gila had already completed the activities/interventions and was now in compliance with the one or more of the standards for which a CAP was required.

The performance improvement activities proposed by Pinal/Gila included revising and strengthening its policies, procedures, and processes; enhancing provider and member education; and improving management of encounters.

## *Performance Measure Review*

Table 3-18 presents the performance measure rates for the contractor. The table shows the following: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, the CYE 2005 minimum AHCCCS performance standard, the AHCCCS goal, and the AHCCCS long-range benchmark.

| Table 3-18—Performance Measurement Review *for* Pinal/Gila | | | | | | | |
|---|---|---|---|---|---|---|---|
| Performance Measure | Actual Performance for Oct. 1, 2003 to Sept. 30, 2004 | Actual Performance for Oct. 1, 2004 to Sept. 30, 2005 | Relative Percent Change | Significance Level* | CYE 2005 Minimum AHCCCS Performance Standard | AHCCCS Goal | AHCCCS Long-Range Benchmark |
| Initiation of HCBS** | 89.1% | 84.1% | -5.6% | p=.450 | 84% | 85% | 98% |
| Diabetes Management—HbA1c Testing | 87.3% | 90.2% | 3.4% | p=.498 | 75% | 77% | 85% |
| Diabetes Management—Lipid Screening | 81.4% | 90.2% | 10.8% | p=.064 | 76% | 78% | 81% |
| Diabetes Management—Retinal Exams | 73.5% | 84.8% | 15.4% | p=.041 | 45% | 47% | 64% |
| EPSDT Participation | N/A | 33.0% | N/A | N/A | 50% | 53% | 80% |

Notes:

*Significance Levels (p-value) noted in the table were performed by AHCCCS and demonstrate the statistical significance between the performance for the previous remeasurement period and actual performance for the current period. Statistical significance is traditionally reached when the p-value ≤ .05.

**HCBS is Home and Community-Based Services.

N/A is shown because EPSDT participation rates were newly reported for CYE 2006.

Table 3-18 shows improved performance for the contractor for three of the four measures with comparable rates, although only the rate for retinal exams changed by a statistically significant amount (i.e., $p \leq .05$). The rate for initiation of HCBS declined by a relative 5.6 percent, but the amount was not statistically significant. The final rate of 84.1 percent was slightly above the minimum AHCCCS performance standard of 84 percent. This measure could become a strength for the contractor to the extent that intensified or revised interventions result in a reversal of the current decline in performance and continued improvement in the rates.

The HbA1c testing rate for diabetes management improved a relative 3.4 percent between measurement periods, but the amount was not statistically significant. The final rate of 90.2 percent, however, was well above the AHCCCS goal of 77 percent. For these reasons, this measure is considered a strength for the contractor.

The rate for the diabetes management—lipid screening measure improved by a relative 10.8 percent between the two most recent measurement periods. This amount of improvement was not statistically significant, but was close to being so. The final rate of 90.2 percent was, however, well above the AHCCCS goal of 78 percent. For these reasons, this measure is also considered a strength for the contractor.

Between measurement periods, the rate for the retinal exam measure for diabetes management improved a relative 15.4 percent, which was a statistically significant amount. The final rate of 84.8 percent was also well above the AHCCCS goal of 47 percent. This measure is also considered a strength.

Pinal/Gila's EPSDT participation rate of 33.0 percent was the lowest of the six contractors and well below the minimum AHCCCS minimum performance standard of 50 percent. As the contractor's

rate is below the required minimum, this measure is considered as a high-priority opportunity for improvement.

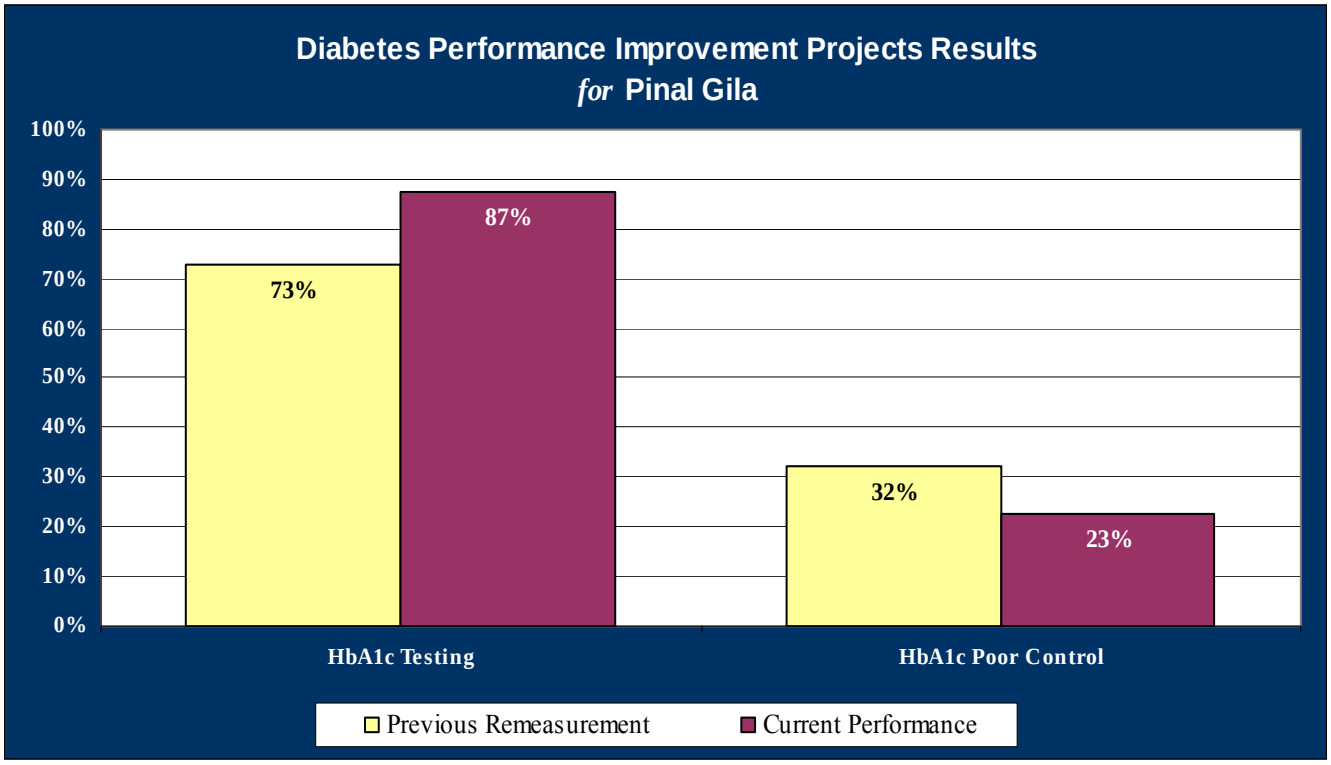
### Performance Measures—CAPs

The contractor had only one required CAP (i.e., EPSDT participation rate) for the performance measure review. As this is the first year of reporting for this measure, next year's report will show comparative data and the results of the CAP from this year.

## Review of PIPs

Figure 3-7 presents the change in PIP performance for the two most recent measurement periods. The figure shows improvement for both measures of diabetes management and control. The contractor's current rate for HbA1c testing is 87 percent and just below the 90th percentile from the 2005 national HEDIS Medicaid results of 88.8 percent. The HbA1c poor control rate of 23 percent is considerably better than the 90th percentile from the 2005 national HEDIS Medicaid results of 31.1 percent.[3-11] The rates for both measures of diabetes management are recognized strengths for Pinal/Gila.

**Figure 3-7—Change in PIP Study Indicator Rates for Pinal/Gila**




As part of its final evaluation for the diabetes management PIP Pinal/Gila reported that it plans to continue the interventions that proved successful in more effectively managing diabetes. The

[3-11] The reason that the lower rate of 23 percent is better than the 90th percentile rate of 31.1 percent is the reversed structure of the measure whereby lower rates are indicative of better performance.

interventions included: conducting education/training for the providers, tracking data and reporting compliance rates at quarterly quality management meetings, holding "lunch and learn" educational discussions, hosting award dinners for providers who meet diabetes management goals, providing diabetic education classes for members and family caregivers at community locations, conducting pre-diabetic outreach programs to educate individuals on how to identify symptoms, conducting follow-up disease management through the Home Alone Programs, administering a pay-for-performance program rewarding provider compliance with diabetic care indicators, and contracting with providers to conduct eye exams in nursing facilities. The exceptionally high outcomes, from a national perspective, suggest that the contractor's combination of interventions could be used as a statewide best practice model.

A new PIP that focused on management of comorbid diseases was started by the contractors during the current review cycle. Table 3-19 presents the baseline results for this PIP. The table shows that the mean number of inpatient days and the mean number of outpatient encounters were both higher than the statewide averages, while the mean number of ER/UC visits was somewhat lower. Presumably, more outpatient visits/encounters would be associated with fewer inpatient days and ER/UC visits. The results will be reviewed again in the next reporting cycle.

**Table 3-19—Performance Improvement Projects—Comorbid Disease *for* Pinal/Gila**

| PIP Measure | Program contractor Baseline Measure—October 1, 2002–September 30, 2003 | Statewide Baseline Measure—October 1, 2002–September 30, 2003 |
|---|---|---|
| Mean Number of Inpatient Days | 18.43 | 15.92 |
| Mean Number of ER/UC Visits | 0.27 | 0.59 |
| Mean Number of Outpatient Encounters | 74.65 | 59.58 |

Note: The denominator for all three measures is the number of eligible members in the sample frame who reside in their home and have at least two of the specified diseases.

The strategies identified by Pinal/Gila to improve rates for management of comorbid/coexisting conditions included: coordinating PCP appointments to ensure members were seen at the PCP-requested frequency; having care managers attend quarterly meetings related to changes in the performance improvement program, compliance of members in the program, and prevention strategies; maintaining a database that tracked member compliance with screenings and evaluations; conducting community educational outreach programs; initiating a pay-for-performance program for select providers related to compliance with performance goals; and conducting member evaluations for those receiving attendant care and in assisted living facilities under the acute care program.

## *Strengths, Opportunities for Improvement, and Recommendations for Pinal/Gila*

The next three sections discuss: (1) findings from AHCCCS' assessment of the sufficiency of the contractor's CAPS which were required by AHCCCS as a result of the findings from the prior year's full OFR, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths for the area of review that were found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

## Compliance with Standards (Operational and Financial Review)

### Strengths

In assessing the sufficiency of the CAPs/associated documentation, AHCCCS determined that for all 16 of the required CAPs, the activities and interventions specified in the CAPs/associated documentation: (1) could be reasonably anticipated to correct the identified deficiencies and bring Pinal/Gila back into compliance with the AHCCCS standards and/or (2) demonstrated that Pinal/Gila had already completed the activities/interventions and was now in compliance with the one or more of the standards for which a CAP was required.

AHCCCS also approved the Pinal/Gila Network Development and Management Plan and commended Pinal/Gila for its efforts to secure more residential beds in Pinal County and for its initiative in coordinating services with outside organizations in the contractor's geographic service area.

### Opportunities for Improvement and Recommendations

With no open and continuing CAPs remaining from the 2004-2005 OFR, no opportunities for improvement or recommendations are offered for Pinal/Gila for the current review.

## Performance Measure Review

### Strengths

With three of the five measures exceeding the AHCCCS goals (i.e., the three measures of diabetes management) and a fourth that exceeded the minimum AHCCCS performance standard (i.e., initiation of HCBS), the performance for the measures overall would normally be considered a success. Yet, the EPSDT rate was the lowest of the six contractors. For this reason, performance on the measures is considered a qualified strength.

### Opportunities for Improvement and Recommendations

The EPSDT participation measure is a high-priority opportunity for improvement for the contractor.

Recommendation: Given that (1) performance for the EPSDT participation measure was an outlier in terms of the contractor's performance on all other measures—which was commendable, and (2) the rate was the lowest of all contractors, Pinal/Gila should consider conducting an analysis of the types of interventions that have been most successful in improving provider performance and member participation/follow-through on other improvement initiatives to determine if similar interventions are currently being used or could be included among the strategies implemented to improve performance on the EPSDT participation measure. In addition, given that other contractors have been considerably more successful for this measure, Pinal/Gila should also consider consulting with one or more of the more successful contractors as to the interventions and strategies that have proven effective in improving participation rates.

## Review of PIPs

### Strengths

The rates for the diabetes control measures were among the best in the nation, being functionally equivalent to or exceeding the 90th percentile from the 2005 national HEDIS Medicaid results. Further, substantive improvement was suggested by the improvement in rates between the two most recent measurement cycles.

### Opportunities for Improvement and Recommendations

Because the diabetes management PIP has been closed, there are no opportunities for improvement or recommendations offered for the current review cycle for the PIP.

For the comorbid disease PIP, the contractor submitted a series of proposed interventions to improve its results. The improvement activities and interventions described appear to be solid and reasonable strategies for improving performance for this PIP.

Recommendations: The contractor should also consider implementing a rigorous process for monitoring its performance for the comorbid disease PIP and a rapid cycle approach to its schedule for evaluating the success of the interventions and, if indicated, for modifying them accordingly.

# Yavapai County Long Term Care (Yavapai)

## *Compliance with AHCCCS' Required Corrective Actions Related to the Standards (Operational and Financial Review)*

For Yavapai, Table 3-20 presents each of the nine categories of technical standards assessed for the CY 2004–2005 comprehensive OFR, total number of technical standards in each category, number of CAPs required, and number of continuing CY 2005–2006 CAPs for each category.

**Table 3-20—Overview of Total CAPs Required *for* Yavapai**

| Categories of Technical Standards | Total Number of Standards CY 2004-2005 | Number of CY 2004–2005 CAPs | Number of Continuing CY 2005–2006 CAPs |
|---|---|---|---|
| Administrative Management | **25** | 2 | 0 |
| Behavioral Health | **8** | 0 | 0 |
| Delivery System | **16** | 1 | 0 |
| Encounters | **15** | 0 | 0 |
| Financial Management | **12** | 1 | 0 |
| Grievance System | **16** | 7 | 0 |
| Case Management | **5** | 0 | 0 |
| Quality Management | **11** | 6 | 1 |
| Utilization Management | **11** | 3 | 0 |
| **Total** | **119** | **20** | **1** |

The CY 2004–2005 review identified one or more standards within several categories that required a CAP. In assessing the sufficiency of the CAPs/associated documentation, AHCCCS determined that for all but 1 of the 20 required CAPs, the activities and interventions specified in the CAPs/associated documentation: (1) could be reasonably anticipated to correct the identified deficiencies and bring Yavapai back into compliance with the AHCCCS standards and/or (2) demonstrated that Yavapai had already completed the activities/interventions and was now in compliance with the one or more of the standards for which a CAP was required.

Yavapai's proposed improvement activities included: revising and strengthening its policies and procedures; enhancing provider monitoring, and enhancing member education through updated materials.

The single continuing CAP was for QM2.1: "*The Program contractor must have a system in place for credentialing and recredentialing providers included in their contracted service provider network.*" The contractor had a credentialing program in place, but its credentialing policy and procedures were not complete and fully compliant with the AHCCCS requirements and AHCCCS recommended the following:

- "The policy must contain timelines for completion of each type of credentialing as per Chapter 950 of the AHCCCS Medical Policy Manual (AMPM). The policy must also contain the following provisions from Chapter 900 of the AMPM:
  - Granting of temporary or provision credentials may occur when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process.
  - Temporary, or provisional, credentialing is intended to increase the available network of providers in medically underserved areas, whether rural or urban.
- The policy should include a statement that an application for credentialing is required, and should include a sample of such an application".

### Performance Measure Review

Table 3-21 presents the performance measure rates for Yavapai. The table shows the following: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, the CYE 2005 minimum AHCCCS performance standard, the AHCCCS goal, and the AHCCCS long-range benchmark.

**Table 3-21—Performance Measurement Review *for* Yavapai**

| Performance Measure | Actual Performance for Oct. 1, 2003 to Sept. 30, 2004 | Actual Performance for Oct. 1, 2004 to Sept. 30, 2005 | Relative Percent Change | Significance Level* | CYE 2005 Minimum AHCCCS Performance Standard | AHCCCS Goal | AHCCCS Long-Range Benchmark |
|---|---|---|---|---|---|---|---|
| Initiation of HCBS** | 90.0% | 92.3% | 2.6% | p=1.00 | 84% | 85% | 98% |
| Diabetes Management—HbA1c Testing | 73.0% | 67.7% | -7.2% | p=.435 | 75% | 77% | 85% |
| Diabetes Management—Lipid Screening | 68.5% | 46.2% | -32.5% | p=.002 | 76% | 78% | 81% |
| Diabetes Management—Retinal Exams | 70.8% | 54.8% | -22.5% | p=.026 | 45% | 47% | 64% |
| EPSDT Participation | N/A | 93.0% | N/A | N/A | 50% | 53% | 80% |

Notes:

*Significance Levels (p-value) noted in the table were performed by AHCCCS and demonstrate the statistical significance between the performance for the previous remeasurement period and actual performance for the current period. Statistical significance is traditionally reached when the p-value ≤ .05.

**HCBS is Home and Community-Based Services.

N/A is shown because EPSDT participation rates were newly reported for CYE 2006.

Table 3-21 shows mixed performance, with the rates for one of the measures improving (not by a statistically significant amount) and three declining (two by statistically significant amounts). The rate for initiation of HCBS improved slightly, but the gain was not statistically significant. The final rate of 92.3 percent was, however, above the CYE 2005 minimum AHCCCS performance standard and the AHCCCS goal. This measure is considered a strength for the contractor.

The HbA1c testing rate for diabetes management declined by a relative 7.2 percent between measurement periods, but the amount was not statistically significant. However, the final rate of

67.7 percent was below the CYE 2005 minimum AHCCCS performance standard of 75 percent, required a CAP to address strategies for improving performance, and is considered an opportunity for improvement

The rate for diabetes management—lipid screening declined by a relative 32.5 percent between the two most recent measurement periods. This amount of decline was highly statistically significant as well as being of substantive clinical importance. The decline was from 68.5 percent to 46.2 percent. This significant decline, in concert with the final rate being almost 30 percentage points lower than the minimum AHCCCS performance standard, suggests that this measure should be a high-priority opportunity for improvement.

The diabetes management—retinal exam rate showed a similar, but not quite as extreme, decline as the lipid screening measure. The retinal exam rate declined by a relative 22.5 percent between the two most recent measurement periods. This amount of decline was highly statistically significant as well as being of substantive clinical importance. The decline was from 70.8 percent to 54.8 percent. The final rate, however, was above the AHCCCS goal of 47 percent. This result suggests that the contractor should consider conducting a root cause analysis in an effort to identify any intervening variables or other factors that may be contributing to the decline in performance rates as a first step for reversing the decline in performance and continuing to improve on the contractor's previous performance levels.

The EPSDT participation rate of 93.0 percent is a seen as a strength. From the relative perspective of the scores from each of the contractors for this measure, Yavapai was the second highest performer of the six contractors. As an additional point of comparison, the contractor's performance also greatly exceeded the AHCCCS goal of 53 percent.

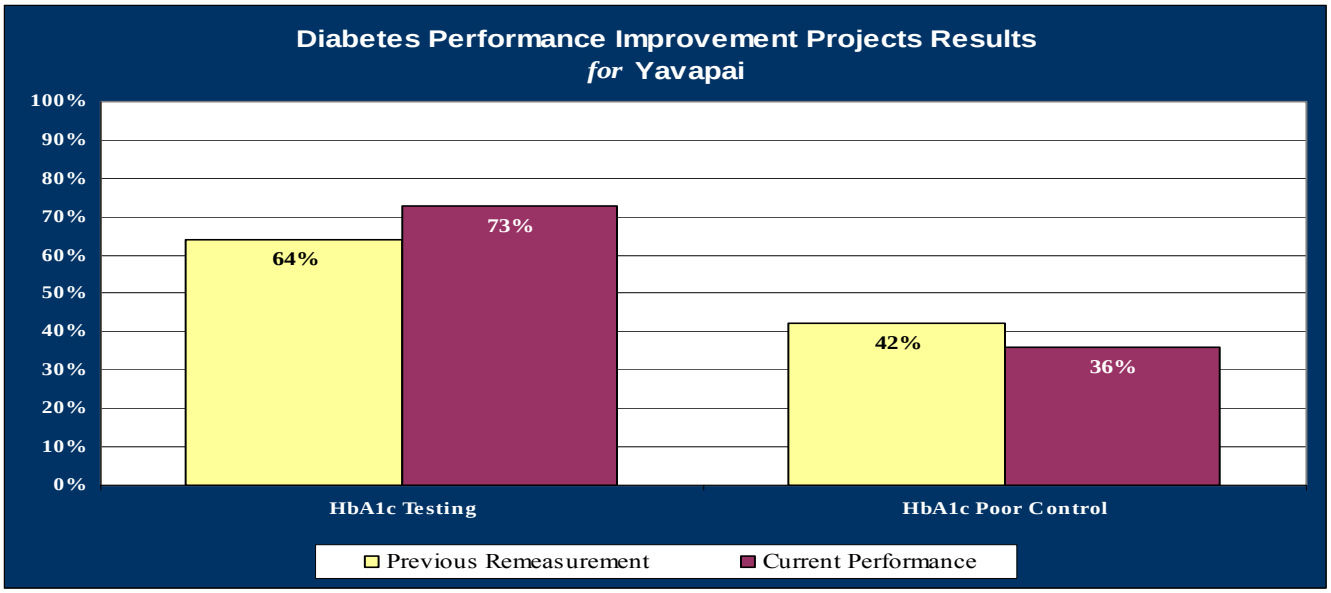
### Performance Measures—CAPs

The contractor had two required CAPs for the performance measures. Both measures (i.e., HbA1c testing and lipid screening) were in the area of diabetes management. The rate for the HbA1c testing measure was somewhat below the 25th percentile from the 2005 national HEDIS Medicaid results of 69.8 percent. The lipid screening rate was well below the 10th percentile from the 2005 national HEDIS Medicaid results of 61.8 percent. Both rates were below the minimum AHCCCS standard.

## *Review of PIPs*

Figure 3-8 presents the change in PIP performance for the two most recent measurement periods. The figure shows improvement for both measures of diabetes management and control. The current contractor's rate for HbA1c testing is 73 percent, which is between the 25th and the 50th percentiles from the 2005 national HEDIS Medicaid results (i.e., 69.8 percent and 78.4 percent, respectively). The HbA1c poor control rate of 36 percent approximates the 25th percentile from the 2005 national HEDIS Medicaid results of 37.8 percent.

**Figure 3-8—Change in PIP Study Indicator Rates for Yavapai**




As part of the final evaluation for the diabetes management PIP, Yavapai reported that its improvements were largely due to dietician contact with each new member who was diagnosed with diabetes. Once engaged, the member was enrolled in the disease management program and educated about diabetes. Care managers also notified disease management staff and the dietician when existing members were diagnosed with diabetes. These members received additional education and outreach by disease management staff. Yavapai also reported having expanded its disease management program to include all diabetics in HCBS to improve members' compliance related to behaviors and diet. Yavapai reported that it will continue to monitor HbA1c screening in order to ensure compliance with the clinical practice guideline and to identify any additional areas for intervention and further improvement.

A PIP focused on the management of comorbid disease was started by the contractors during the current review cycle. Table 3-22 presents the baseline results for this PIP. The table shows that the mean number of inpatient days was substantively lower than the statewide average, the mean number of ER/UC visits was nearly equal to the statewide average; and the mean number of outpatient encounters was higher than the statewide average.

**Table 3-22—Performance Improvement Projects—Comorbid Disease *for* Yavapai**

| PIP Measure | Program contractor Baseline Measure—October 1, 2002–September 30, 2003 | Statewide Baseline Measure—October 1, 2002–September 30, 2003 |
|---|---|---|
| Mean Number of Inpatient Days | 6.02 | 15.92 |
| Mean Number of ER/UC Visits | 0.51 | 0.59 |
| Mean Number of Outpatient Encounters | 71.06 | 59.58 |

Note: The denominator for all three measures is the number of eligible members in the sample frame who reside in their home and have at least two of the specified diseases.

The next measurement period will address changes that occur with the contractor's performance improvement plan. Yavapai identified the following strategies for improving the rates for management of comorbid/coexisting conditions: care managers identified and referred members with COPD, CHF, and/or diabetes to a health management nurse; health management nurses provided disease management information to caregivers; care managers identified and referred diabetic members to dieticians for evaluation and education; the contractor hired and trained clinical case managers (i.e., RNs) to work with the diabetic members; staff researched available practice guidelines and compared guidelines to a sample of current member profiles to determine the degree of member compliance; and care management staff used face-to-face visits and telephone calls to members to ensure that members were complying with their care plans.

## *Strengths, Opportunities for Improvement, and Recommendations for Yavapai*

The next three sections discuss: (1) findings from AHCCCS' assessment of the sufficiency of the contractor's CAPs which were required by AHCCCS as a result of the findings from the prior year's full OFR, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths for the area of review that were found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

### Compliance with Standards (Operational and Financial Review)

#### Strengths

In assessing the sufficiency of the CAPs/associated documentation, AHCCCS determined that for all but 1 of the 20 required CAPs, the activities and interventions specified in the CAPs/associated documentation: (1) could be reasonably anticipated to correct the identified deficiencies and bring Yavapai back into compliance with the AHCCCS standards and/or (2) demonstrated that Yavapai had already completed the activities/interventions and was now in compliance with the one or more of the standards for which a CAP was required.

AHCCCS also approved the Yavapai Network Development and Management Plan and commended Yavapai on its extensive evaluation of the prior year's plan, the use of the Program Development Unit in developing the plan and managing the network, and its plan for addressing changes in the pattern and volume of member needs.

#### Opportunities for Improvement and Recommendations

The one CAP/associated documentation that AHCCCS assessed as not yet sufficient and is continuing was for the technical standard QM2.1: "*The Program contractor must have a system in place for credentialing and recredentialing providers included in their contracted service provider network*." The contractor had a credentialing program in place, but its credentialing policy and procedures were not complete and fully compliant with the AHCCCS requirements.

Recommendation: The contractor should consider conducting a complete review of, and as applicable, revising its credentialing policies and procedures, to ensure that they are complete, current, and detailed in defining the requirements and processes for credentialing and recredentialing contracted service providers. The review and revision should ensure that the policies

and procedures include and are consistent with those prescribed by the AHCCCS policies (including those—as recommended by AHCCCS and requiring the CAP—related to timelines for completing each type of credentialing, granting temporary/provisional credentials, and the required application). Yavapai should also consider assessing whether it has sufficient processes and accountabilities for ensuring that the policies and procedures are updated as needed to remain complete, current, and consistent with AHCCCS policies.

## Performance Measure Review

### Strengths

Performance for the EPSDT participation measure is a definite strength for the contractor. With the performance rate of 93.0 percent, the second highest among the contractors, Yavapai's performance considerably exceeds the AHCCCS goal of 53 percent. The contractor is recognized for its exceptionally high rate of performance on this measure.

### Opportunities for Improvement and Recommendations

The contractor had two required CAPs related to the performance measures. Both measures (i.e., HbA1c testing and lipid screening) were in the area of diabetes management. The rates for both measures were well below the 50th percentile from the 2005 national HEDIS Medicaid results and below the AHCCCS minimum required standard.

Recommendation: The contractor should consider conducting an evaluation to determine whether the current interventions are broad enough in number, scope, and areas targeted to bring about the desired increase in performance rates and, based on the outcome of the evaluation, Yavapai should strengthen its current strategies and/or add additional interventions. If not currently doing so, the contractor should consider evaluating the availability of testing/screening that can be performed at the same time and in the same location as routine PCP office visits and evaluating the probable impact of increasing this availability as one way to potentially decrease barriers to obtaining the testing. In addition, the contractor should consider evaluating whether provider and member informational materials are sufficient in frequency of distribution and in content to compel provider compliance and reduce member resistance to the testing. If not currently in place, the contractor may also want to consider implementing a system of provider incentives and sanctions/withholds related to performance and member incentives for obtaining the needed tests/screenings.

## Review of PIPs

### Strengths

The diabetes management PIP was successfully conducted and closed. The comorbid disease management PIP is too new to have shown strengths.

### Opportunities for Improvement and Recommendations

Because the diabetes management PIP has been closed, there are no opportunities for improvement or recommendations offered in the current review cycle for the PIP.

For the comorbid disease PIP, the contractor has submitted a series of proposed interventions to improve its results. The interventions that the contractor has described appear to have been thoughtfully selected and to be reasonable and sound as strategies for improving performance for the comorbid disease PIP.

Recommendation: The contractor should also consider implementing a rapid cycle approach to the frequency with which it evaluates the impact and success of the interventions in improving performance and for modifying them accordingly.

# Arizona Department of Economic Security (DES)/Division of Developmental Disabilities (DDD)

## *Compliance With Standards (Operational and Financial Review)*

In addition to a review of DDD's required corrective actions resulting from AHCCCS' findings for the 2004–2005 OFR, AHCCCS also conducted a extensive on-site 2005–2006 OFR for DDD. AHCCCS provided information to HSAG to allow a cross-walk comparison of the results from the 2004–2005 review with those from the 2005–2006 review.

**Figure 3-9—CYE 2006 Compliance with Technical Standards *for* DDD**

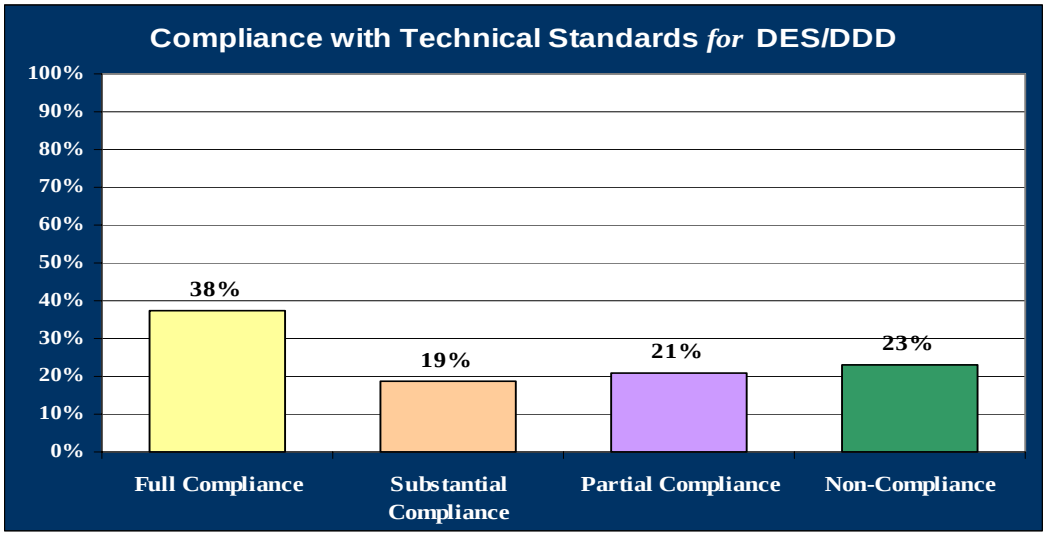



Figure 3-9 shows that performance for approximately 38 percent of the technical standards was assessed to be in Full Compliance with the requirements. However, performance for 23 percent of the technical standards was assessed as Non-Compliance. Overall, performance for approximately 63 percent of the technical standards shows opportunities for improvement to reach Full Compliance.[3-12]

Yet, Figure 3-9 can obscure categories within the technical standards that show varying degrees of success. Figure 3-10 presents each of the standards and each of the levels of compliance with the requirements of the technical standards (i.e., Full, Substantial, Partial, and Non-Compliance). Some caution is advised, however, when comparing the percentages across categories, as the number of standards within each category can be small.

[3-12] The percentages in Figure 3-9 sum to 101 percent due to rounding.

**Figure 3-10—Categorized Levels of Compliance with Technical Standards *for* DDD**

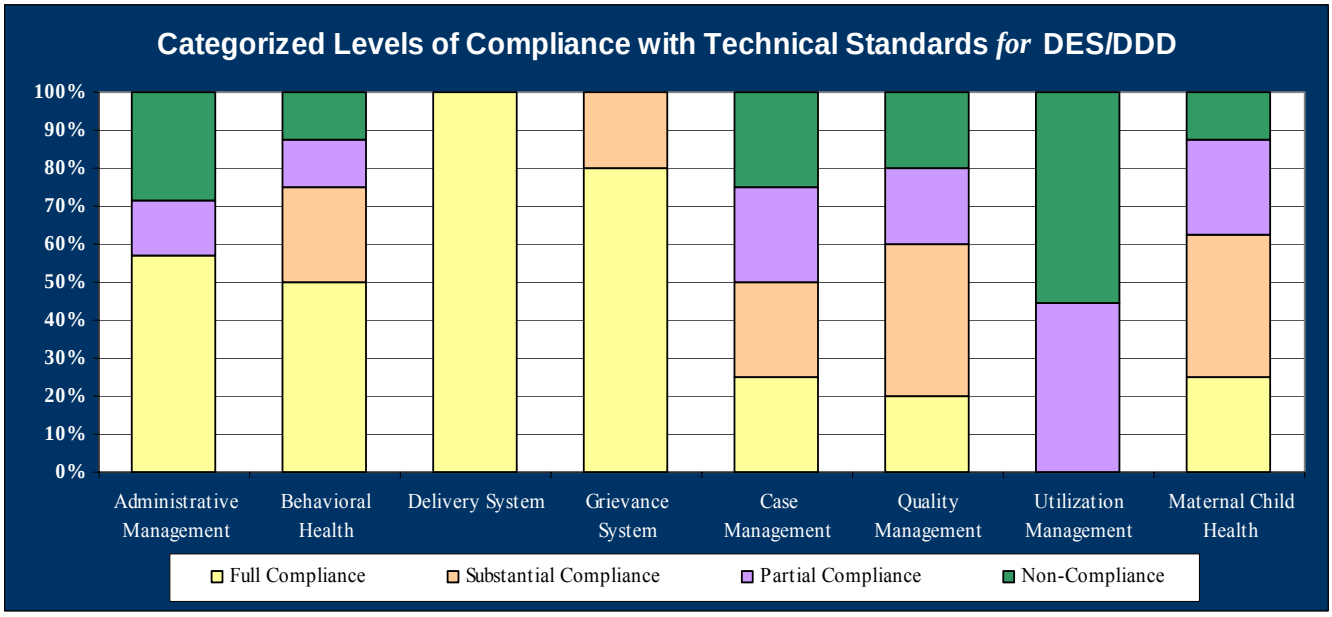
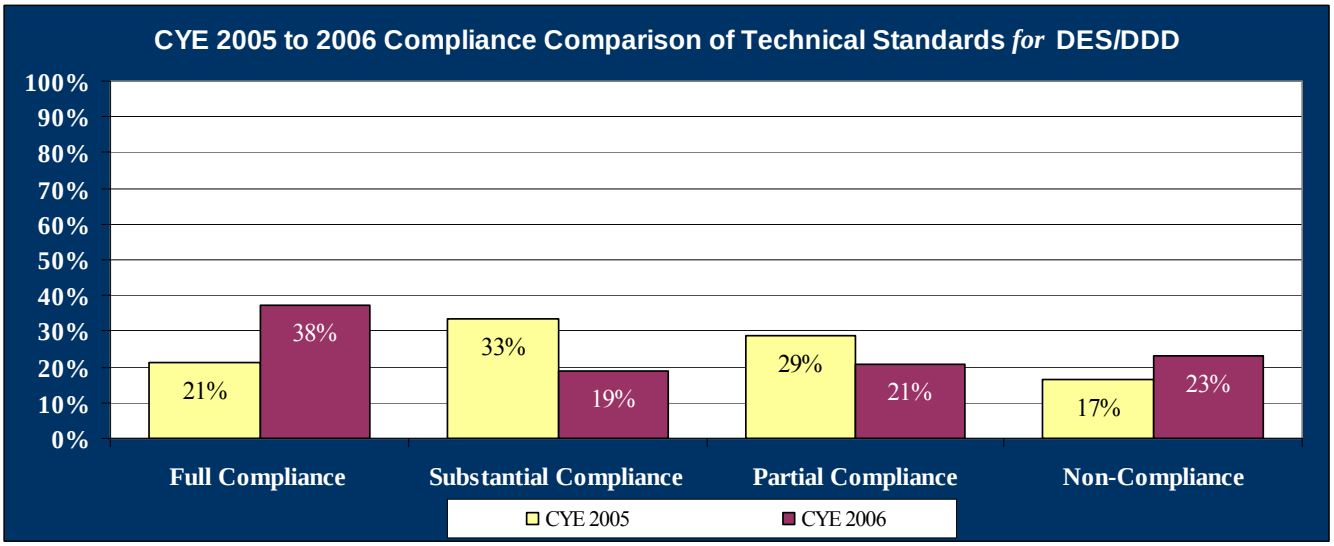



Figure 3-10 shows that the Delivery System category (with only two standards) was assessed as in Full Compliance. Figure 3-10 also indicates that the standards related to utilization management should be considered as a high priority opportunity for improvement for DDD.

Figure 3-11 presents the proportion of standards in Full, Substantial, Partial, and Non-Compliance for the technical standards assessed for 2004–2005 and for 2005–2006. Caution is again advised when interpreting the figures, as the number of standards within each category was not constant across the two assessment years.

**Figure 3-11—Two-Year Compliance with Technical Standards *for* DDD**



Even accepting the caveat, Figure 3-11 shows a higher proportion of the assessed technical standards in Full Compliance during the current review cycle than in the previous review. Nonetheless, the figure also shows a higher proportion currently in Non-Compliance than was seen in the previous review. Even given the improvement, the 63 percent of technical standards that are not in Full Compliance represent a very significant and widespread opportunity for improvement.

## CAPs for Compliance with Standards

Although the numbers of technical standards within each review area changed between the two assessment years, an evaluation of the change in the percentage of each category's standards that required a CAP is interpretable within the restraints imposed by the small numbers of technical standards within each category. Table 3-23 presents the number of required CAPs and its percentage of each category's standards for the two most recent assessment cycles.

**Table 3-23—Two-Year CAP Overview *for* DDD**

| Categories of Technical Standards | CYE 2005 Number of CAPs | CYE 2005 Percent of Category Standards (N=42) | CYE 2006 Number of CAPs | CYE 2006 Percent of Category Standards (N=48) |
|---|---|---|---|---|
| Administrative Management | 3 | 60% | 3 | 43% |
| Behavioral Health | 3 | 38% | 4 | 50% |
| Delivery System | 1 | 100% | 0 | 0% |
| Grievance System | 4 | 80% | 1 | 20% |
| Case Management | 2 | 100% | 3 | 75% |
| Quality Management | 4 | 100% | 4 | 80% |
| Utilization Management | 8 | 89% | 9 | 100% |
| Maternal Child Health | 7 | 88% | 6 | 75% |
| **Total** | **32** | **76%** | **30** | **63%** |

Table 3-23 shows that most of the categories of standards had a lower percentage of required CAPs in the present review cycle than in the previous review. Further, the number of CAPs declined from 32 to 30, while the number of technical standards being reviewed increased from 42 to 48. Combined, these findings suggest that DDD made progress in bringing its performance on the technical standards into compliance. Nonetheless, given that 63 percent of the technical standards required a CAP, significant opportunities for improvement remain.

## *Performance Measure Review*

Table 3-24 presents the performance measure rates for DDD. The table shows the following: the previous performance, the current performance, the relative percentage change, the statistical significance of the change, the CYE 2005 minimum AHCCCS performance standard, and whether a CAP was required for each measure. The system of rotating measures across assessment years results in the assessment years shown in the notes to the table for the various selected performance measures.

**Table 3-24—Performance Measurement Review *for* DDD**

| Performance Measure | Prior Performance* | Current Performance** | Relative Percent Change | Significance Level* | CYE 2005 Minimum AHCCCS Performance Standard | CAP Required |
|---|---|---|---|---|---|---|
| Well-Child Visits—First 15 Months[1] | N/A | N/A | N/A | N/A | N/A | N/A |
| Well-Child Visits—3 to 6 Yrs[2] | N/A | 42.3% | N/A | N/A | N/A | N/A |
| Adolescent Well-Care Visits[2] | N/A | 31.4% | N/A | N/A | N/A | N/A |
| Annual Dental Visits | 32.7% | 39.3% | 16.8% | p<.001 | 35% | No |
| Child Immunization—4 DTaP | 67.3% | 73.0% | 7.8% | p=.354 | 83% | Yes |
| Child Immunization—3 IPV | 72.1% | 84.3% | 14.5% | p=.028 | 89% | Yes |
| Child Immunization—1 MMR | 89.4% | 84.3% | -6.0% | p=.268 | 90% | Yes |
| Child Immunization—3 HiB | 76.0% | 81.7% | 7.0% | p=.295 | 76% | No |
| Child Immunization—3 HBV | 66.3% | 83.5% | 20.6% | p=.003 | 82% | No |
| Child Immunization—1 VZV | 80.8% | 82.6% | 2.2% | p=.725 | 77% | No |
| Child Immunization—DTP, IPV, & MMR (4:3:1 Series) | 59.6% | 71.3% | 16.4% | p=.069 | 80% | Yes |
| Child Immunization—DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) | 45.2% | 65.2% | 30.7% | p=.003 | 70% | Yes |
| EPSDT Participation[3] | N/A | 50.0% | N/A | N/A | 51% | Yes |

Notes:

* The previous remeasurement period for Annual Dental Visits was October 1, 2002 through September 30, 2003. The previous remeasurement period for Child Immunizations was October 1, 2003 through September 30, 2004.

** The current remeasurement period for Well-Child Visits – 3 to 6 Years, Adolescent Well-Care Visits, and Annual Dental Visits was October 1, 2003 through September 30, 2004. The current remeasurement period for Child Immunizations and EPSDT Participation was October 1, 2004 through September 30, 2005.

[1] Only one member met the continuous enrollment criteria for Well-Child Visits in the First 15 Months of Life, so a rate could not be calculated for this measure.

[2] Baseline rates for Well-Child Visits – 3 to 6 Years, and Adolescent Well-Care Visits are being used to establish DDD Performance Standards for the CYE 2007 contract renewal.

[3] The EPSDT Participation rate is the number of children younger than 21 years receiving at least one medical screen during the contract year, compared to the number of children expected to receive at least one medical screen. The number of children expected to receive at least one medical screen is based on the AHCCCS EPSDT periodicity schedule and the average period of eligibility. This is the first measurement period for EPSDT Participation.

The table shows that for well-child visits within the first 15 months, where only one member met the criteria for the measure, a rate could not be calculated. The rates for the measures of well-child visits for members from three to six years old and for adolescent well-care visits at 42.3 percent and 31.4 percent, respectively, are being used as baseline measurements for future comparisons.

The performance rate for the annual dental visits measure saw a relative increase of 16.8 percent, which was statistically significant. The rate improved from below the 2005 minimum AHCCCS performance standard to above it. DDD is commended for this improvement in performance.

The Child Immunization rates for 4 DTaP and 3 IPV both showed improvement, with the 3 IPV rate improving by a statistically significant amount. Nonetheless, both measures were still below the 2005

minimum AHCCCS performance standards. Childhood Immunizations for 1 MMR saw a relative decrease of 6.0 percent, which was statistically non-significant; however, the resulting rate of 84.3 percent was below the 2005 minimum AHCCCS standard of 90 percent. All three measures are, therefore, high-priority opportunities for improvement.

The rates for Childhood Immunizations for 3 HiB, 3 HBV, and 1 VZV saw improvements, with the rate for 3 HBV improving by a statistically significant amount. All three of these measures saw final rates that exceed the 2005 minimum AHCCCS performance standards.

The rates for Childhood Immunizations for DTP, IPV, & MMR (4:3:1 Series) and DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) both increased. The increase for the first rate was close to reaching statistical significance and the increase for the second rate was in an amount that was highly statistically significant. Nonetheless, as the table shows, neither rate reached the 2005 minimum AHCCCS performance standards.

The final rate presented in the table is the EPSDT participation rate. Although in its first year of reporting, DDD's rate of 50 percent was just short of the 2005 minimum AHCCCS performance standard of 51 percent.

## Performance Measures—CAPs

Table 3-25 presents the required CAPs from the most recent two measurement periods for each of the performance measures. The table shows limited improvement, with one fewer required CAPs in the present review than in the previous review. The current review, however, includes a required CAP for EPSDT participation, which was not assessed in a previous review. The reduction in required CAPs, therefore, is more justifiably from seven to five for comparable measures.

| Table 3-25—Performance Measurement CAPs *for* DES/DDD | | | | | |
|---|---|---|---|---|---|
| **Performance Measure** | **Previous Remeasurement Period*** | **Current Performance**** | **Minimum AHCCCS Performance Standard** | **CYE 2005 CAP Required** | **CYE 2006 CAP Required** |
| Well-Child Visits—First 15 Months[1] | N/A | N/A | N/A | N/A | N/A |
| Well-Child Visits—3 to 6 Yrs[2] | N/A | 42.3% | N/A | N/A | No |
| Adolescent Well-Care Visits[2] | N/A | 31.4% | N/A | N/A | No |
| Annual Dental Visits | 32.7% | 39.3% | 35% | Yes | No |
| Child Immunization—4 DTaP | 67.3% | 73.0% | 83% | Yes | Yes |
| Child Immunization—3 IPV | 72.1% | 84.3% | 89% | Yes | Yes |
| Child Immunization—1 MMR | 89.4% | 84.3% | 90% | Yes | Yes |
| Child Immunization—3 HiB | 76.0% | 81.7% | 76% | No | No |
| Child Immunization—3 HBV | 66.3% | 83.5% | 82% | Yes | No |
| Child Immunization—1 VZV | 80.8% | 82.6% | 77% | No | No |
| Child Immunization—DTP, IPV, & MMR (4:3:1 Series) | 59.6% | 71.3% | 80% | Yes | Yes |
| Child Immunization—DTP, IPV, MMR, HIB, & HBV (4:3:1:3:3 Series) | 45.2% | 65.2% | 70% | Yes | Yes |
| EPSDT Participation[3] | N/A | 50.0% | 51% | N/A | Yes |
| **Total PM CAPs** | | | | **7** | **6** |

Notes:

* The previous remeasurement period for Annual Dental Visits was October 1, 2002 through September 30, 2003. The previous remeasurement period for Child Immunizations was October 1, 2003 through September 30, 2004.

** The current remeasurement period for Well-Child Visits—3 to 6 Years, Adolescent Well-Care Visits, and Annual Dental Visits was October 1, 2003 through September 30, 2004. The current remeasurement period for Child Immunizations and EPSDT Participation was October 1, 2004 through September 30, 2005.

N/A is Not Assessed.

1 Only one member met the continuous enrollment criteria for Well-Child Visits in the First 15 Months of Life, so a rate could not be calculated for this measure.

2 Baseline rates for Well-Child Visits – 3 to 6 Years, and Adolescent Well-Care Visits are being used to establish DDD Performance Standards for the CYE 2007 contract renewal.

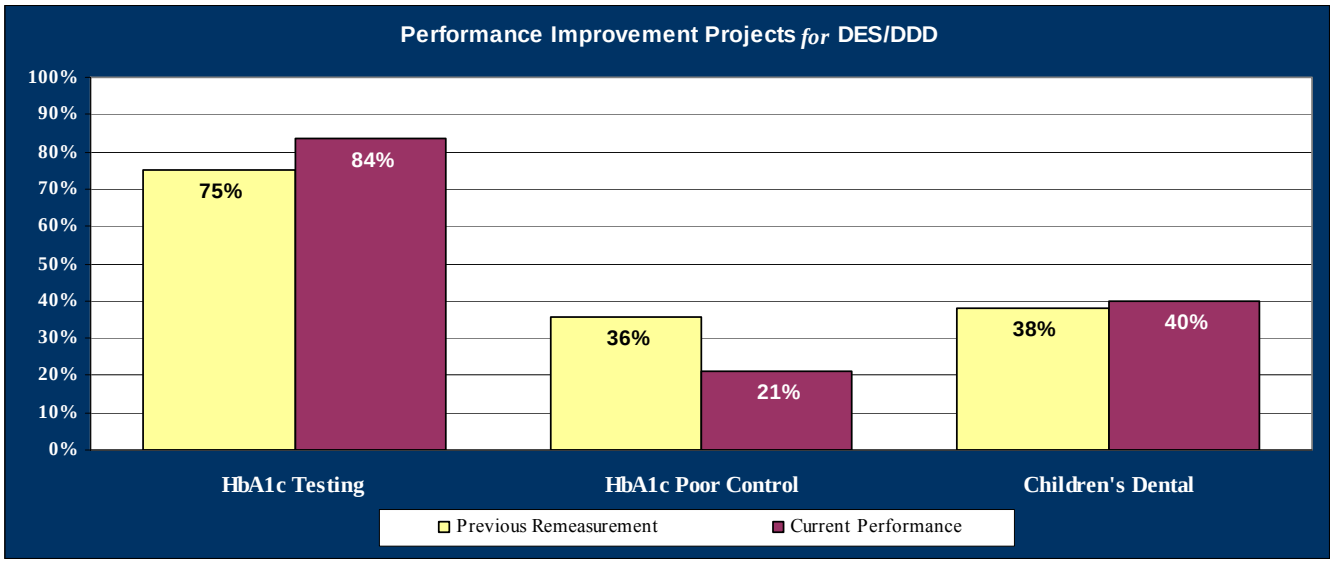
3 The EPSDT Participation rate is the number of children younger than 21 years receiving at least one medical screen during the contract year, compared to the number of children expected to receive at least one medical screen. The number of children expected to receive at least one medical screen is based on the AHCCCS EPSDT periodicity schedule and the average period of eligibility. This is the first measurement period for EPSDT Participation.

## Review of PIPs

Figure 3-12 presents the change in PIP performance for the two most recent measurement periods. The figure shows improvement for both measures of diabetes management and for the children's dental measure. DDD's rate for HbA1c testing is 84 percent, which is equivalent to the 75th percentile from the 2005 national HEDIS Medicaid results of 84.1 percent. The HbA1c poor control rate of 21 percent is considerably better than the 90th percentile from the 2005 national HEDIS

Medicaid results of 31.1 percent.[3-13] The rate for HbA1c poor control is a recognized strength for DDD. The 40 percent rate for the children's dental measure, while improved, was between the 25th and 50th 2005 national HEDIS Medicaid percentile rates of 37.4 percent and 44.5 percent, respectively.

**Figure 3-12—PIP Results *for* DDD**




The diabetes PIP was completed in 2006. As part of its final evaluation for the diabetes management PIP, DDD attributed the success largely to increased awareness across the system of the importance of incorporating HbA1c tests as part of an effective health care strategy and higher quality of life. DDD and its subcontracted health plans distributed a number of informational materials related to diabetes education to providers, members, and staff (e.g., Clinical Quality Bulletin, memos to support coordinators, and articles addressing diabetes education that were included in the DDD Update newsletters). DDD also reported on its collaborative efforts with its subcontracted health plans to continually educate staff, providers, and members on the importance of HbA1c testing and monitoring.

Although it was not mandated by AHCCCS, DDD conducted a third remeasurement of the diabetes management PIP as part of its own performance improvement program. This remeasurement occurred for the period of October 1, 2004, through September 30, 2005. The DDD rates for HbA1c testing and poor control continued to demonstrate improvement.

A second remeasurement was conducted for the PIP to increase children's oral dental visits. The project is ongoing since not all of the health plans' providers have demonstrated significant and sustained improvement. DDD reported that it will continue to compare results among its health plans/providers to identify any trends which will prompt further action with individual health plans and/or their providers.

[3-13] The reason that the lower rate of 21 percent is better than the 90th percentile rate of 31.1 percent is the reversed structure of the measure whereby lower rates are indicative of better performance.

## Strengths, Opportunities for Improvement, and Recommendations for DDD

The next three sections discuss: (1) compliance with standards/substandards resulting from the findings of the operational and financial review, (2) performance measures, and (3) PIPs. Each of these three sections presents the strengths for the area of review that were found in the documentation provided to HSAG, opportunities for improvement, and recommendations.

### Compliance with Standards (Operational and Financial Review)

### Strengths

The results of the review of DDD's compliance with the standards showed an improvement in the percentage of standards in Full Compliance and a reduction in the percentage of technical standards requiring a CAP as compared to results for the prior year's review. Notwithstanding this improvement, the fact that approximately 63 percent of the technical standards were not in Full Compliance for the current review is considerably stronger evidence that compliance with the technical standards is not an overall strength for DDD.

### Opportunities for Improvement and Recommendations

The only category of standards that did not have a required CAP was the Delivery System category, which included only 2 of the 48 total standards assessed in the current review. This result shows that DDD's opportunities for improvement in complying with requirements for the technical standards are overarching across the remaining seven categories of standards and DDD's related operations.

Opportunities for improvement were quite generalized for DDD as shown in Table 3-23. The recommended approach to improvement in this situation is somewhat different from improving performance for a single category of standards. With performance on the standards for seven of the eight categories needing improvement, the quality improvement issue becomes one of finding root causes underlying the failure to achieve sufficiently high compliance across almost all of the categories under review. While not minimizing the importance of and need for DDD to focus improvement activities targeted to those individual aspects of performance for each standard for which performance was not fully compliant, it seems important for DDD to first undertake a comprehensive review of its systems and operations and those of its subcontracted health plans to detect those common and consistent barriers to performance that compromise its performance across multiple categories of standards.

Recommendation: At the DDD level, DDD should consider either (1) appointing a cross-departmental project team that is empowered to conduct a rigorous and comprehensive systems review and analysis designed to identify probable root causes that contribute to DDD and its subcontracted health plans not having performed in Full Compliance with the requirements for seven of the eight categories and to make recommendations that target what may be revealed as common or similar variables affecting performance across categories; or (2) engage external resources skilled in facilitating a comprehensive systems analysis to provide the leadership and to work with the staff members in conducting this kind of review. The systems review should be broad and inclusive of: (1) organizational structure and reporting (2) written policies and procedures (e.g.,

complete and detailed; clear, consistent with current AHCCCS and other binding requirements, etc.); (3) operational practices (e.g., adhere to policies and procedures, clear accountabilities for each process, etc.), (4) tightness of linkages/interface/hand-offs between and among related or interdependent systems and processes; (5) monitoring performance of internal/external staff/providers/delegates/vendors (e.g., targeted and specific, frequent, quality/sufficiency of processes and tools); (6) infrastructure to support required operations (e.g., staffing, information systems/technology, communications, etc.); and other areas as identified by DDD as important to a complete and comprehensive review of its systems and operations.

At the level of the subcontracted health plan/their providers, upon which DDD is dependent for improving performance across most of the standards, DDD should also consider conducting a comparison/profiling of health plan performance on the standards to identify any clear patterns of differences in performance among the health plans. DDD should then consider engaging those health plans where performance is not in compliance with the requirements in identifying the root causes for the failure to comply and require the health plans to submit targeted corrective action plans.

DDD should consider conducting an assessment to determine whether it currently has monitoring processes and activities to provide DDD with sufficiently frequent and detailed feedback about the performance of the health plans related to the AHCCCS standards and based on the outcomes of the assessment, DDD should strengthen the frequency of and/or the tools used for its monitoring activities.

## Performance Measure Review

### Strengths

Performance for 4 of the 10 performance measures met or exceeded the 2005 minimum AHCCCS performance standards. These measures are considered strengths for DDD's program. In addition, for comparable measures, the number of required CAPs decreased between the two measurement periods from seven to five, which is also a recognized sign of improvement.

### Opportunities for Improvement and Recommendations

The measures for which performance rates did not meet the minimum AHCCCS performance standard, particularly those that also showed a decline in performance, and required CAPs are, by definition, opportunities for improvement. The measures for which performance met or exceeded the minimum AHCCCS standards do not appear to cluster in a manner that would be useful in capitalizing on the strengths from some of the measures to improve performance for the others.

Recommendations: Not withstanding the above statement, DDD should work with its subcontracted health plans/their providers and review any interventions/strategies that are common to those measures in which performance met or exceeded the minimum required levels in order to determine whether those same interventions/strategies are or could potentially be incorporated as part of the interventions for those measures not meeting the required performance levels. When performance declines, it is always important to consider whether any interventions were dropped or modified or whether unanticipated or unplanned intervening variables could have accounted for or contributed

to the decline. DDD should consider conducting this kind of review with its subcontracted health plans for those measures for which performance declined.

In addition to other activities that DDD may conduct to identify the probable contributing causes for performance not meeting the minimum standards and the targeted interventions to improve performance, DDD should consider reviewing and analyzing with the health plans the hours of provider availability in comparison to the times of the day and days of the week that working parents/guardians whose children are eligible for Medicaid services can typically bring their children to see a PCP and, if indicated by the analysis, require increased provider availability in the evenings and on weekends. DDD should also consider whether its health plans have sufficient provider and member reminder systems in place and whether enhancing the systems and/or enhancing the frequency and content of member informational materials have potential for improving performance.

To the extent that these and/or other DDD-identified interventions do not appear effective in increasing performance, DDD should consider working with the subcontracted health plans in conducting a comprehensive provider and member profiling project. This project should focus on identifying patterns of less than acceptable performance for individual providers and provider group practices related to each of the performance measures as well as any clear patterns of member characteristics for those not receiving the appropriate immunizations or otherwise participating in the EPSDT program as compared to those that are. Specific and targeted interventions could then focus on the providers with the poorest performance and those members whose parents/guardians are not participating in ensuring the desired preventative health care for the members. Also, if not already in place, DDD may want to encourage its health plans to consider implementing a provider performance recognition/incentive and/or sanction/withhold program and incentives/rewards for the parents/guardians who comply with ensuring that members receive required immunizations and otherwise participate in the EPDST program of well-child visits.

Finally, DDD should consider identifying and implementing strategies designed to improve the collection of services provided to members through third part liability insurance as a mechanism to ensure that all applicable services provided are captured and reported for including in the performance measure calculations.

## Review of PIPs

### Strengths

DDD's performance for the diabetes PIP was quite successful and the PIP is now closed. The final rates were very respectable when compared with national rates. This PIP was a recognized strength for DDD's program.

### Opportunities for Improvement and Recommendations

Performance for the children's dental PIP has not yet reached the required level and, as a result, this PIP is continuing.

In addition to the recommendations offered above for improving performance on the required measures, DDD should also work with the subcontracted health plans and assess whether there is an opportunity to significantly enhance the content and the frequency/timing, and methods of distributing educational information to parents/guardians. In addition, DDD, working with the health plans, may want to consider whether there are sufficient member appointment reminder systems in place and systems for follow-up with the parents/guardians when timely appointments have not been encountered. DDD, working with its health plans, should consider whether there is an opportunity to enhance communication with the PCPs as to the expectations and the importance of their role in informing parents/guardians about the importance of the dental visits and encouraging the parents/guardians to schedule appointments, ideally before leaving the PCP's office.

## Compliance with Standards (Operational and Financial Review)

For the EPD contractors, AHCCCS conducted a focused follow-up review for the 2005-2006 monitoring of compliance with AHCCCS standards. The follow-up desk reviews were to assess the sufficiency of the contractors' CAPs and associated documentation submitted in response to significant AHCCCS findings from the prior year's (2004–2005) comprehensive OFR. AHCCCS reviewed and assessed each contractor's proposed corrective action plans and associated documentation. From this review, AHCCCS determined if: (1) the activities and interventions specified in the corrective action plans could reasonably be anticipated to correct the deficiencies identified during the 2004–2005 OFR and bring the contractor back into compliance with the applicable AHCCCS standards; and/or (2) the documentation demonstrated that the contractor had implemented the required action(s) and was now in compliance with one or more of the standards requiring a CAP; and/or (3) additional or revised corrective action plans or documentation were still required from the contractor for one or more standards and the CAP process was still open and continuing. For DDD, AHCCCS conducted an extensive review of DDD's performance in complying with contract requirements for both the 2004-2005 and the 2005-2006 operational and financial review cycles, therefore, the 2005–2006 results for DDD can not be compared with those of the six EPD contractors.

### *CAPs for Compliance with Standards*

Table 4-1 presents for each EPD contractor, the number of required CAPs resulting from the AHCCCS review of technical standards for the CY 2004–2005 OFR and the number of continuing CAPs following AHCCCS' 2005-2006 evaluation of the sufficiency of the contractors' CAPs and associated documentation. The EPD contractors include Cochise, Evercare, Mercy, Pima, Pinal/Gila, and Yavapai and are the same contractors used for all of the comparative results in this section of the report.

**Table 4-1—Comparison of CAPs for Technical Standards *for* All EPD Program Contractors**

| Category | Number (%) of Standards with CAPs for CY 2004-2005 | Number of Standards with Continuing CAPs CY 2005-2006 |
|---|---|---|
| Cochise | 19/(16%) | 0 |
| Evercare | 22/(18%) | 1 |
| Mercy Care | 24/(20%) | 0 |
| Pima | 15/(13%) | 0 |
| Pinal/Gila | 16/(13%) | 0 |
| Yavapai | 20/(17%) | 1 |
| **All Plans** | **116/(16%** | **2** |

The table shows that in assessing the sufficiency of the CAPs/associated documentation, AHCCCS determined that for four of the six contractors, the activities and interventions specified in their CAPs/associated documentation: (1) could be reasonably anticipated to correct the identified deficiencies and bring the contractors back into compliance with the AHCCCS standards and/or (2) demonstrated that the contractors had already completed the activities/interventions and were now in compliance with one or more of the standards for which a CAP was required. As a result, there were no open and continuing caps for Cochise, Mercy Care, Pima and Pinal Gila.

For both Evercare and Yavapai, AHCCCS determined that with the exception of one CAP each, the activities and interventions specified in their CAPs/associated documentation: (1) could be reasonably anticipated to correct the identified deficiencies and bring the contractors back into compliance with the AHCCCS standards and/or (2) demonstrated that the contractors had already completed the activities/interventions and were now in compliance with one or more of the standards for which a CAP was required.

For Evercare the one CAP/associated documentation that AHCCCS assessed as not yet sufficient and is continuing was for the technical standard UM1.1—"*The Program contractor has written policies and procedures for utilization management program requirements which are consistent with AHCCCS standards.*" Evercare was assessed as in Substantial Compliance for this standard for the 2004-2005 OFR. For Yavapai, the single continuing CAP was for the technical standard QM2.1: "*The Program contractor must have a system in place for credentialing and recredentialing providers included in their contracted service provider network.*" Yavapai was assessed as in Partial Compliance for this standard for the 2004-2005 OFR.

## Performance Measure Review

Table 4-2 presents the rates for each performance measure by contractor. The table also shows the AHCCCS minimum performance standards, goals, and long-range benchmarks. Presented in this manner, the results from the contractors can be compared with one another and with the AHCCCS minimum standards, goals and long-range benchmarks.

**Table 4-2—Results for the Most Recent Performance Measures *for* All EPD Contractors**

| Performance Measure | Cochise | Evercare | Mercy Care | Pima | Pinal/ Gila | Yavapai | Minimum AHCCCS Perf. Standard | AHCCCS Goal | AHCCCS Long-Range Bench-mark |
|---|---|---|---|---|---|---|---|---|---|
| Initiation of HCBS Services | 95.6% | 90.0% | 85.6% | 91.9% | 84.1% | 92.3% | 84% | 85% | 98% |
| Diabetes Management—HbA1c Testing | 79.4% | 69.3% | 77.1% | 70.6% | 90.2% | 67.7% | 75% | 77% | 85% |
| Diabetes Management—Lipid Screening | 78.4% | 66.5% | 78.6% | 75.3% | 90.2% | 46.2% | 76% | 78% | 81% |
| Diabetes Management—Retinal Exams | 68.0% | 85.6% | 51.7% | 61.9% | 84.8% | 54.8% | 45% | 47% | 64% |
| EPSDT Participation | 95.0% | 58.0% | 46.0% | 65.0% | 33.0% | 93.0% | 50% | 53% | 80% |
| **Average Rate** | **83.3%** | **73.9%** | **67.8%** | **72.9%** | **76.5%** | **70.8%** | **66%** | **68%** | **82%** |

The table shows that Cochise had the highest average rate, at 83.3 percent and was the only contractor meeting all of the minimum AHCCCS performance standards. In addition Cochise's rates exceeded all of the AHCCCS goals. Cochise is recognized for this outstanding achievement.

The average rate for every contractor exceeded the average minimum AHCCCS performance standard. This average finding, however, obscures the individual levels of achievement and opportunities for improvement for each contractor.

One method of comparison looks at the number of rates where each contractor had the highest rate for the five measures. By this standard, the highest rate for two of the five measures was achieved by both Cochise and Pinal/Gila, followed by Evercare with the highest rate for a single measure. The two highest rates for Pinal/Gila were for the diabetes management laboratory measures. This finding of similar patterns of strength for the two measures is not unusual, as both involve the need to obtain a blood sample. The correlation between the two rates for the six contractors is fairly high at 0.85. These findings support the concept that increasing the rate for one of the measures would be anticipated to increase the other, although Yavapai's rates for these two measures were more than 20 percentage points apart.[4-1]

The rates for the initiation of HCBS services ranged from 84.1 percent for Pinal/Gila to 95.6 percent for Cochise. Rates for all six contractors exceeded the minimum AHCCCS performance standard. Five of the six contractors exceeded the AHCCCS goal of 85 percent.

The overall results for the diabetes management HbA1c testing and lipid screening measures saw three contractors meeting the minimum AHCCCS performance standards. All three of these contractors also exceeded the AHCCCS goals.

For diabetes management—retinal exams, all six contractors exceeded the minimum AHCCCS performance standard of 45 percent and the AHCCCS goal of 47 percent.

In its first year of reporting, the minimum AHCCCS performance minimum standard and goal for EPSDT participation were exceeded by four of the six contractors. These contractors are recognized for this accomplishment.

## Performance Measures—CAP

Table 4-3 presents information as to whether a CAP was required for each of the contractors for each of the performance measures. The table shows that none of the contractors required a CAP for either the initiation of HCBS services measure or for the diabetic retinal exams measure. The contractors are recognized for their successes in these areas. The results for the HbA1c testing and lipid screening measures, however, each saw three contractors with required CAPs and the EPSDT measure resulted in two contractors with required CAPs.

[4-1] The correlation between the laboratory measures without the Yavapai data is 0.94 – generally considered a very high result.

| Table 4-3—Performance Measures—Corrective Action Plan Required *for* All EPD Contractors | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Performance Measure** | **Cochise** | **Evercare** | **Mercy Care** | **Pima** | **Pinal/ Gila** | **Yavapai** | **Total** |
| Initiation of HCBS Services | No | No | No | No | No | No | **0** |
| Diabetes Management—HbA1c Testing | No | Yes | No | Yes | No | Yes | **3** |
| Diabetes Management—Lipid Screening | No | Yes | No | Yes | No | Yes | **3** |
| Diabetes Management—Retinal Exam | No | No | No | No | No | No | **0** |
| EPSDT Participation | No | No | Yes | No | Yes | No | **2** |
| **Total Performance Measure CAPs** | **0** | **2** | **1** | **2** | **1** | **2** | **8** |

Cochise led the contractors with no required CAPs for any of the five measures. Mercy Care and Pinal/Gila each had one required CAP, and Evercare and Pima had two required CAPs each. Overall performance for the five measures for the six contractors resulted in eight required CAPs, statewide. These eight required CAPs represent 27 percent of the 30 total number of possible CAPs that could have been required with lesser performance.

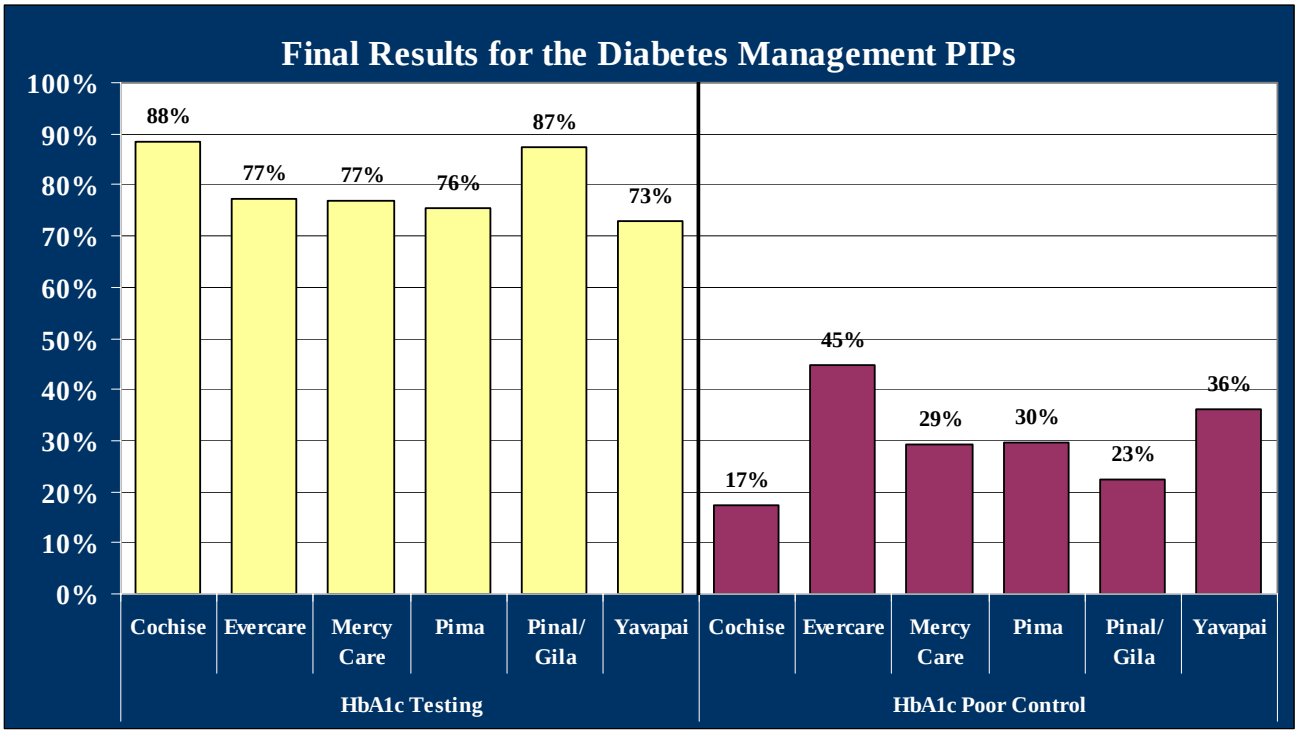
## Review of PIPs

Figure 4-1 presents the final results from the diabetes management PIPs,[4-2] which have since been closed. The table shows that Cochise and Pinal/Gila had the two highest rates for HbA1c testing at 88 percent and 87 percent, respectively. Although the rate for Yavapai was the lowest at 73 percent, it was substantively equivalent to the 76 percent to 77 percent range in rates from the other three remaining contractors. These results suggest that HbA1c testing is a relative strength for Cochise and Pinal/Gila.

Due to the reverse structure of the HbA1c Poor Control measure, lower rates are indicative of better performance. Again, Cochise and Pinal/Gila led the contractors with rates of 17 percent and 23 percent, respectively. Following in performance, Mercy Care and Pima showed rates of 29 percent and 30 percent, respectively. Evercare and Yavapai posted the lowest performance at 45 percent and 36 percent, respectively.

[4-2] Evercare did not demonstrate significant and sustained improvement during the previous remeasurement period. Therefore, Evercare rates reported are from Oct. 1, 2003-Sept. 30, 2004 and Oct. 1, 2004-Sept. 30, 2005, respectively.

**Figure 4-1—Final Results for Diabetes Management *for* All EPD Contractors**




Contractors were also responsible for reporting baseline values for three measures of comorbid disease management, the mean numbers of inpatient days, ER/UC visits, and outpatient encounters. Table 4-4 presents the average rates for the three measures from the six contractors and statewide. Changes in these rates will be assessed in the report for the following year's findings. Although the mean number of outpatient encounters across contractors shows an almost random correlation with inpatient days, the correlation between the mean number of outpatient encounters and the mean number of ER/UC visits is -0.71. This correlation is reasonable evidence to suggest that increasing the mean number of outpatient visits/encounters could be expected to have a positive impact on decreasing the mean number of ER/UC visits.

| Table 4-4—Performance Improvement Projects—Comorbid Disease *for* All EPD Contractors | | | |
|---|---|---|---|
| **Program contractor** | **Baseline Measure—October 1, 2002–September 30, 2003** | | |
| | **Mean Number of Inpatient Days** | **Mean Number of ER/UC Visits** | **Mean Number of Outpatient Encounters** |
| Cochise | 16.6 | 0.92 | 43.7 |
| Evercare | 21.2 | 0.46 | 82.2 |
| Mercy Care | 12.4 | 0.45 | 43.8 |
| Pima | 20.9 | 0.93 | 42.2 |
| Pinal/Gila | 18.4 | 0.27 | 74.7 |
| Yavapai | 6.0 | 0.51 | 71.1 |
| **Program contractor Average** | **15.9** | **0.59** | **59.6** |

Note: The denominator for the three measures is the number of eligible members in the sample frame who reside in their home and have at least two of the specified diseases.

With the correlation of only 0.22, the mean number of inpatient days did not appear to be more than weakly, if at all, associated with the mean number of ER/UC visits. This finding suggests that members might be using the ER/UC visits as a substitute for office visits for reasons of geographic convenience or during times (evenings/week-ends) when provider offices are closed in addition to those times when their condition becomes too serious for an office visit. The impact of the contractors' planned interventions, which were submitted to AHCCCS and presented in Section 3 of this report, will be assessed in the next measurement cycle.

## Overall Strengths and Opportunities for Improvement

In assessing the sufficiency of the EPD contractors 116 total CAPs/associated documentation submitted in response to findings of less than full compliance with the AHCCCS standards assessed for the 2004–2005 OFR, AHCCCS determined that for four of the six contractors, the activities and interventions specified in their CAPs/associated documentation: (1) could be reasonably anticipated to correct the identified deficiencies and bring the contractors back into compliance with the AHCCCS standards and/or (2) demonstrated that the contractors had already completed the activities/interventions and were now in compliance with one or more of the standards for which a CAP was required. As a result, there were no open and continuing caps for Cochise, Mercy Care, Pima and Pinal Gila for the 2005–2006 follow-up review. AHCCCS determined that for each of the two remaining contractors (Evercare and Yavapai), the CAPs and documentation were sufficient for all but one of the standards which differed for each contractor. As a result, Evercare and Yavapai each have one open and continuing CAP for the 2005–2006 follow-up review. AHCCCS follows up on the implementation of required corrective actions and reviews the related outcomes during its ongoing monitoring and oversight of the contractors' performance as well as during future OFRs. These activities determine whether the CAPs were effective in bringing the contractors back into compliance with AHCCCS regulations and contract requirements.

For the performance measures, the rates for all six of the contractors exceeded both the AHCCCS minimum required performance standard and the AHCCCS goal for the retinal exams for diabetes management and rates for three of the six exceeded the AHCCCS long range benchmark. While not all contractors' performance exceeded the AHCCCS minimum for each performance measure and the statewide average was relatively flat for performance for the initiation of HCBS measure and for HbA1c testing and lipid screening, the average rate across all measures for every contractor exceeded the average minimum required rates for the measures. No CAPs were required for one of the contractors related to the performance measures, and the 8 total required CAPs combined for the remaining contractors was only 27 percent of the total possible 30 CAPs that could have been required for lesser performance. Overall statewide, performance was mixed with some rates declining between the two most recent measurement periods, but the contractors' seem generally successful in identifying and implementing effective program strategies to improve performance related to the required measures of access to timely, quality care. Overall, performance on the required measures could be considered as a somewhat qualified strength, as the average statewide performance rates that exceeded the minimum required by AHCCCS were heavily influenced by the contractors whose performance significantly exceeded the minimum required.

While the diabetic management and control PIP has been closed, the contractors' performance for both measures improved between the two remeasurement periods, with the statewide rate for HbA1c poor control of 29 percent exceeding the 90$^{th}$ percentile of the 2005 national HEDIS® Medicaid results (which was 31.1 percent). The rates for initiation of HCBS and for retinal exams for members with diabetes are recognized strengths for the statewide EPD contractors.

## Overall Recommendations

Of the 116 required CAPs/associated documentation submitted across the six contractors in response to findings from the 2004–2005 comprehensive OFR, only two CAPs and the associated documentation, which were not for the same standard or the same contractor, remained open and continuing for the 2005–2006 follow-up review. As a result no additional overall opportunities or recommendations for improvement are offered for compliance with the standards beyond those for the two individual contractors as described in detail in Section 3 of this report.

As a solid first approach to improving performance on required measures where performance rates are flat or declining and/or do not meet even the minimum standard required, the EPD contractors are encouraged to consider (1) conducting a root cause analyses in an effort to identify any changes to the improvement strategies or other intervening variables that may have contributed to the failure of the rates to improve, and most importantly for any declines in the rates. Conversely, root cause analyses can also be useful in identifying intervention strategies determined as having contributed to significant improvement in rates for similar measures. These findings may point to interventions that could improve performance for measures where the rates failed to improve, declined, and/or remained below the AHCCCS CYE 2005 minimum performance standard or goal.

The overall recommendations for improving performance on the required measures that emerge from the comparative analysis converge on the same statewide recommendations as offered in the beginning of Section 3 of this report. Two measures of diabetes management (i.e., HbA1c testing and lipid screening) saw required CAPs for half of the State's contractors. Both measures are

opportunities for improvement for the three impacted contractors. Based on the rationale as described in Section 3, a statewide recommendation for the improvement of measures requiring drawing of blood samples is for the contractors to consider implementing or increasing the availability of care/service delivery models among the providers in the network where drawing the required blood samples can be done during routine medical visits. Combined with enhanced provider office and member appointment remainder systems, the additional member convenience might be very effective in improving the rates. When not currently doing so, the contractors should also consider one or both of the following additional strategies: (1) implementing a system of provider performance rewards/incentives and/or sanctions/withholds and member incentives for having the testing/screenings completed; and (2) focusing intensified or additional intervention strategies on those providers who's performance has been identified through performance profiling as most needing improvement and those members whose characteristics have been shown, through profiling of member compliance, to be the least likely to follow-through with the testing/screening. This multi-faceted approach has the potential to have a synergistic effect in improving performance on the required measures of timely access to quality care.

As the diabetes management and control PIP and related measures have been closed and performance on both measures improved, there are no opportunities or recommendations for improvement offered for this PIP. The second PIP that focused on the management of comorbid disease was initiated statewide by the contractors during the current review cycle and the data available for this PIP was limited to the contractors' baseline measurement rates. As a result, there are no overall opportunities for improvement or recommendations offered for this PIP.